Putting integrated care into practice: the North West London experience

Evaluation of the Whole Systems Integrated Care programme

Research report
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Acknowledgements

Contents

The Whole Systems Integrated Care (WSIC) programme in North West London is a bold initiative that builds on prior developments such as integrated care and community budgets pilots. It seeks to improve quality of care for a population of over two million people. The WSIC programme is the largest of the 14 integrated care pioneers launched by the Coalition Government in 2013 to remove barriers to integrated care and enable it to be extended 'at scale and pace'.

The Nuffield Trust and the London School of Economics and Political Science were commissioned to evaluate the WSIC programme's early stages from February 2014 to late April 2015, independently assessing the initial processes and progress to date. The evaluation was formative in nature, providing feedback and challenge as part of the WSIC programme's commitment to adaptive learning. Here we present a summary of our findings.

Key points

- The WSIC programme is ambitious and well resourced through funding from the pooled budgets of the North West London Collaboration of Clinical Commissioning Groups. As a result, it has been able to make significant investments in co-design and planning, before developing pilot schemes, known as 'early adopters'.

- The initial co-design phase was completed roughly within the planned timescale, and its outputs have supported the early adopter phase. However, the programme was more than a year behind schedule when our evaluation ended and had yet to deliver significant service change. As elsewhere, design and planning were characterised by energy and pace, but progress slowed as implementation began.

- National barriers that have slowed progress include difficulties obtaining data-sharing agreements, and clarifying and establishing the necessary information governance arrangements; separate payment systems and governance structures between sectors; and organisational fragmentation. Such barriers cannot be fully removed without the national action promised but yet to be sufficiently fulfilled.

- Locally the programme has had to strike a balance between a number of factors, including collective leadership and local autonomy; integrated commissioning and integrated provision; and NHS leadership and local authority engagement. This has been achieved with varying degrees of success at different points in the process.

- The WSIC programme was seen to be approaching a 'tipping point' when our fieldwork ended in late April 2015. Changes in the programme's leadership around that time had created concerns about the weakening of its strategic management capacity.

- The WSIC programme has been led by NHS commissioners and has tended to reflect their agendas and interests. This focus may reflect a deliberate assessment of where the greatest benefits are to be secured for service users in the current financial climate over the short term.

- Nevertheless, the WSIC programme should consider whether it has given sufficient priority to achieving its broader ambition of preventing ill health and promoting wellbeing. Both the NHS and local authorities should pay greater attention to the potential for a wider local government role in support of the WSIC programme. This approach would require a governance framework capable of engaging with local government as a whole, as well as with the community, third sector and other agencies.

- The extent of lay partner involvement in designing, planning and governing the WSIC programme has been a defining feature of its approach, and provided an additional source of challenge to established practices. However, if timescales slip further, there could be risk that these patients, service users and carers may become frustrated and question the purpose of their involvement.

- While the programme wisely avoided setting early output targets, the systematic monitoring of service use, patient and user experience, and overall cost-effectiveness is now required in order to begin to demonstrate delivery of person-centred outcomes and value for money.

- As accountable care partnerships begin to form, transparent and robust governance and accountability arrangements will be required to accompany them. This will have implications for the roles and responsibilities of commissioners that still need to be clarified locally and nationally.

- The ambitious nature of the programme has enabled a whole health economy approach, but has added complexity in terms of governance and management processes. This evaluation identifies lessons about the need to balance central and local support and resources, and to ensure that the complexities of a pan-North West London approach do not outweigh its advantages.

- The role of the programme team and the value of products such as the toolkit were strongly endorsed in our early adopter survey, although the programme was also criticised in some of our interviews for its overly structured programme management approach.

- The costs of the programme to date are not insignificant: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support. Unsurprisingly in the current financial climate, the evaluation reported findings that questioned the value of such levels of investment in both management consultancy, and the programme team, as well as evidence that their support had been positively appreciated. It is likely that the programme will need to account more explicitly for the cost-effectiveness of its current and past spending, especially in the absence of evidence, to date, that it has secured significant levels of service change on the ground.

- The WSIC programme has sought to maintain an inclusive, learning style, incorporating formative evaluation, lessons learned from the earlier North West London integrated care pilots, international experience and external advice. This commitment to adaptive learning is reflected in its current governance review and should enable it both to reflect on the lessons of this evaluation and address the significant strategic challenges it continues to face.

A summary of this research report is available. More information about the WSIC programme is also available.

1.   Introduction

Background

In 2013, clinical commissioning groups (CCGs) and local authorities from across North West London joined with health, social care and other partners to form an alliance intended to drive the development and implementation of a large-scale programme of integrated care. The alliance, known as the Whole Systems Integrated Care (WSIC) programme, aims to improve service user experience and quality of care for selected populations; reduce unplanned hospital admissions; and achieve financial benefits across the local health and social care system.

The WSIC programme builds on prior initiatives in North West London that likewise sought to foster joint working across sectors and enable better coordinated care for people with a range of health and care needs. These initiatives include the Tri-borough Community Budgets Pilot, and the Inner and Outer North West London Integrated Care Pilots (ICPs). The original Whole Systems Integration Programme, 'Living Longer and Living Well' (subsequently entitled WSIC), was selected in 2013 as one of the Department of Health's national integrated care pioneers.

The WSIC programme was designed in two phases, recognising that it takes time to develop and establish plans for new ways of working, especially if there is to be a significant focus on engaging a wide range of local community and professional interests. The first phase focused on co-designing the WSIC programme (October 2013 until late February 2014) and the second on implementing a set of early adopter schemes – local pilots of integrated care, intended to test out the wider principles and aims of the WSIC programme in a practical manner (from March 2014) prior to implementing these across North West London as a whole. It is these initial phases that have been the subject of the evaluation study, the findings of which are set out in this report.

Overview of the evaluation

The Nuffield Trust and the London School of Economics and Political Science (LSE) were commissioned by Imperial College Health Partners (ICHP), and funded by ICHP and the North West London Collaboration of CCGs, to evaluate the development and implementation of the initial design and piloting phases of the WSIC programme from February 2014 to late April 2015.

The evaluation was primarily qualitative in nature, and sought to provide an independent assessment of:

- the way in which the WSIC programme was designed
- its involvement of local stakeholders in the processes of design
- the development and early implementation of the early adopter schemes
- the extent to which the WSIC programme appeared to be on track towards its objectives.

We were not commissioned to assess the cost-effectiveness of setting up or operating the WSIC programme.

An important aspect of this evaluation was its formative approach: namely, it had a design whereby there was regular interaction and debate between the research team and local stakeholders within the WSIC programme, entailing co-design of research methods, early feedback by researchers of emerging findings, and reflective sessions during which the researchers offered WSIC programme leaders suggestions about next steps, based on research data and analysis. Like the WSIC programme itself, our evaluation had two phases:

1. Assessing how the various local stakeholders were engaged in co-designing the programme, and giving our early impressions of how priorities and plans for the early adopters had been developed (February to June 2014).

2. Studying the development and progress made by the early adopters, including a sample of four selected as case studies, and assessing how far the WSIC programme overall appeared to be on track towards its objectives (July 2014 to late April 2015).

Methods used in the evaluation

The research took place on two levels: tracking developments and perceptions at the pan-North West London level, and taking an in-depth case study approach with four early adopters at the local level (more detail can be found in the Appendix). Our methods for undertaking the evaluation included:

- documentary analysis

- observations of meetings and site visits

- semi-structured interviews

- feedback workshops

- a focus group of early adopter project managers and clinical colleagues

- a survey of early adopter steering committee members (November 2014)

- a survey of GP practices in North West London (March–May 2015).

These activities took place between early February 2014 and late April 2015. In total, we conducted 73 hour-long interviews, face to face or by telephone. Interviewees included managers and professional staff from the acute sector; CCGs; community and mental health services; local authorities; lay partners; third sector representatives; and frontline staff.[1] We also observed approximately 120 hours of meetings at the pan-North West London and local early adopter levels.

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1 Quotes from our interviews have been anonymised and are cited in this report using three-letter alphanumeric codes, which represent the sectors of the various interviewees plus a row number in our master list. The sectors are named as follows: CG for NHS commissioner; FA for facilitator; HP for health provider; LA for local authority; LP for lay partner; PT for WSIC programme team; and TS for third sector. The names of interviewees from each sector in our master list were not ordered alphabetically, but rather determined by random numbers generated for this purpose. The digit within the alphanumeric code therefore has no further meaning beyond its use as a reference.

While our formal data collection period finished at the end of April 2015, we have in some cases included material gathered after this date when it seemed pertinent to do so. Where this has occurred, it has been clearly marked in this report.

All interviews were recorded and transcribed, and subsequently analysed using a framework approach and the qualitative software NVivo. Observation notes were written up by hand and incorporated into our analysis of interviews. Interviewees and other participants have been anonymised for this report.

Surveys

In order to complement our in-depth case study approach with four of the early adopters, we conducted two surveys with a wider group of participants in order to capture wider perceptions of the programme. The first of these was of steering committee members within each of the nine early adopters, and the second was of GP practices across North West London.

The survey of early adopter steering committee members was sent out on 13 November and closed on 17 December 2014. Designed using the online software Survey Monkey, it asked about members' perceptions of their early adopter's progress, the usefulness of the WSIC Integrated Care Toolkit and the toolkit design process, as well as different groups' involvement in the early adopter. A total of 109 steering committee members responded to the survey, leading to a response rate of 60 per cent. However, the response rate varied considerably among the individual early adopters, ranging from 31 per cent to 80 per cent.

The second survey was aimed at GPs in North West London and was distributed by the various CCGs. One GP in each practice was asked to complete it. The majority of CCGs distributed the survey on 24 March 2015, with two CCGs sending it out the following month. The survey was closed on 8 May 2015. It was also designed using the online software Survey Monkey. A total of 160 responses were received, leading to a response rate of 39 per cent (assuming that one person per practice completed the form). Of those who responded to the survey, 11 per cent identified themselves as practice managers, administrators or practice nurses (19 individuals). These responses have been included in our analysis.

Although the survey asked about awareness of the WSIC programme, it was designed primarily to gather views on integrated care and what needs to happen locally to achieve change. It also collected baseline data on perceptions of GPs' relationships with other sectors. The results of this survey were used to inform this report, and individual feedback reports distributed to local areas. Slideshows detailing results of both surveys are available.

This report

This report is structured according to the main aims of our evaluation, namely: the process of design of the WSIC programme, including the involvement of different stakeholders; the development and early implementation of a set of early adopter pilot schemes of integrated care; and reflections on the overall approach to change, followed by an assessment of what was achieved and what lessons this offers for North West London and health and social care more widely.

2.   Background and context

In this chapter we examine what is meant by 'integrated care' and highlight the different ways in which it is put into practice within health and care systems. We point to the evidence base for what integrated care seems to be able to achieve, as the basis for later comparative analysis in chapter 6. We then describe the complex landscape of health and social care across North West London, highlighting some of the major contextual factors, such as changes to the configuration of acute hospital services, and the way in which NHS commissioners work in a highly collaborative manner, with joint management and other support arrangements.

Integrated care

Integrated care is a term typically used to describe attempts to 'improve patient experience and achieve greater efficiency and value from health delivery systems' by redesigning services in such a way as to minimise the fragmentation experienced by some groups of service users (Shaw and others, 2011).[2] Integrated care initiatives target the poor coordination that often exists between general and specialist medicine, and between adult social care and health care, and service users with complex needs whose care is most likely to span these sectors (Shaw and others, 2011).

National Voices describe effective integrated care as being 'person centred coordinated care' that achieves the goals set by the individual; provides support for carers; involves joint care planning; improves communication (with the user and between professionals); involves better information being available for the individual; and involves more inclusive decision-making and improved transitions between sectors (National Voices, 2013).

Models of integrated care are often described as being on a spectrum of the characteristics set out in Box 1.

Evidence suggests that the benefits of integrated care are most likely to be achieved when the model is targeted at the patients most at risk of fragmented care (Curry and Ham, 2010; Goodwin and Smith, 2011; Ham and others, 2011; Rosen and others, 2011) and where case management and care coordination processes are combined with a wider range of interventions that increase access to primary care and independent living, and to preventive measures (Ross and others, 2011). In addition to improving patient experience, integrated care initiatives have been shown to improve professional experience (see, for example, the evaluation of the national Integrated Care Organisations pilot; RAND Europe and Ernst & Young LLP, 2012). However, there is little evidence to date of an integrated care model that has brought about both clinical improvements and economic benefits (Armitage and others, 2009; Bardsley and others, 2013; Nolte and Pitchforth, 2014).

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2 This description of integrated care and its different models is intentionally brief. For more detailed reviews of integrated care and the accompanying literature, we recommend Curry and Ham (2010) and Shaw and others (2011). For a review of the evidence around integrated care, we recommend Bardsley and others (2013).

> ### Box 1: Characteristics of integrated care
>
> **Intensity:**
>
> From an organisational merger to better linkage between service departments or organisations.
>
> **The level at which integration is taking place:**
>
> Macro level – population level, usually involving providers and commissioners.
>
> Meso level – focus on a particular patient group (i.e. disease-specific or age-related).
>
> Micro level – mechanisms implemented for individual users, for example care plans or personal budgets.
>
> **Direction:**
>
> Either horizontal, where integration is taking place between organisations at the same level; or vertical, where sectors or organisations at different levels come together, for example primary and secondary care.
>
> **Organisational form:**
>
> Either real integration where organisations come together and create a single legal entity; or virtual integration where organisations are joined in a network, perhaps by contracts or service agreements.
>
> *Adapted from Curry and others, 2013*

National policy context

Delivering more integrated care has been a concern of English health policy since the Hospital and Community Care Plans of 1962 and 1963. More recent initiatives have included the development of care trusts, managed clinical networks, and the integrated care pilots that arose from the Darzi review in 2008 (Darzi, 2008). This momentum continued into the Health and Social Care Act 2013, which placed a duty on commissioners and regulators to promote integration whilst also monitoring anti-competitive behaviour.

Since then a number of national initiatives have been introduced, all of which have contributed towards shaping the development of the WSIC programme in North West London. These include Community Budgets; the Better Care Fund; the National Integrated Care Pioneer programme; the Prime Minister's Challenge Fund for primary care; and the NHS England Five Year Forward View. Details of how the WSIC programme has embraced these initiatives are set out in chapters 3 and 4.

North West London boroughs

The area covered by the North West London WSIC programme has a population of just over two million people and encompasses the eight London boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and the City of Westminster, which for the most part share their boundaries with those of the eight North West London CCGs. A map of North West London and its constituent boroughs is set out in Figure 1.

Figure 1: London boroughs of North West London

Source: NHS North West London, 2013a, p. 1.

North West London is very diverse geographically, ranging from the semi-rural wards of Hillingdon and Harrow bordering the M25, to the dense urban areas of Westminster and Kensington and Chelsea in the centre. There is also significant variation within individual boroughs and across North West London in terms of deprivation and population health status.

Commissioners in North West London

The commissioner and provider landscape in North West London is complex and consists of organisations with footprints of widely varying sizes, and very different systems of accountability and funding. The extent of collaboration between them also varies substantially. Commissioners in North West London include the eight CCGs, eight local authorities and NHS England North West London local area team. All are official partners within the WSIC programme except for Hillingdon local authority, where the local politicians chose not to be a signatory to the WSIC programme's pioneer bid. The local authority has nevertheless engaged with the Hillingdon early adopter through joint work on the borough's Better Care Fund plan.

NHS commissioners

The eight CCGs collaborate in various ways and groupings. Currently they have formed two commissioning entities: the CWHHE Collaborative (comprising Central London, West London, Hammersmith and Fulham, Hounslow, and Ealing CCGs) and the BHH

Federation (comprising Brent, Harrow and Hillingdon CCGs). They work with the eight local authorities in North West London through the Health and Wellbeing Boards.

They also collaborate as a group of eight CCGs in an entity known as the North West London Collaboration of CCGs. This takes place through a [Collaboration Board](#). Membership and powers of the Collaboration Board vary according to which function it is meeting under. The functions of the Collaboration Board include: general strategic business; shared support services and the annual contracting process; business intelligence and informatics strategy; financial strategy; and primary care co-commissioning.

The North West London Financial Strategy (2014/15 to 2018/19) is a product of this collaboration, alongside supporting five-year strategic and operational plans, and has served as an important enabler of the WSIC programme. The financial strategy has three parts and involves pooling resources to:

- cover the administrative and implementation costs of large-scale change ('transformation') programmes across North West London, including the WSIC programme

- put all CCGs on a level playing field by leaving no CCG in deficit

- create a recurrent investment fund to support investment in out-of-hospital services across North West London.

The history of collaborative arrangements among health commissioners and providers in North West London is long, and the work of the North West London Collaboration of CCGs can be seen as a continuation and deepening of the financial and pan-North West London commissioning arrangements that were already taking place within the North West London Primary Care Trust (PCT) cluster and even earlier with the North West London Strategic Health Authority. Indeed, the five-year financial strategy described above essentially recreates key components of the pre-2013 arrangements for commissioning and strategic oversight.

Local authorities

Collaborative arrangements also exist among the local authorities in North West London, but are not as extensive as those between the eight CCGs, nor do they have the same footprint. The largest of these in terms of geography is the West London Alliance. While no pooling of financial resources is involved, the seven councils in the alliance do collaborate in the commissioning of certain adult and children's services, for example allowing them to lead commercial negotiations and contract development as a single client. The main focus of these arrangements, however, has been to achieve savings rather than to align any specific work with the health service.

While smaller in terms of geography, the 'Tri-borough' arrangement between the three central London boroughs of Kensington and Chelsea, Hammersmith and Fulham, and the City of Westminster has had a much larger impact on the WSIC programme. While the collaboration itself was established primarily to 'reduce the cost of bureaucratic overheads and save management costs' by seeking to manage some council services at greater scale,

its role as a Community Budgets Pilot site and its Better Care Fund plan, and the associated Tri-borough Community Independence Service, represent crucial developments in the WSIC programme, as discussed in chapters 3, 5 and 6.

Providers in North West London

General practice and primary care

General practice is a key feature of the WSIC programme and is intended to be the centre of the North West London vision for out-of-hospital care (North West London Collaboration of CCGs, no date). Many of the GP practices in North West London belong to some kind of network or federated arrangement. These arrangements across the eight North West London CCGs are extremely varied in terms of the number of participating practices, as well as their organisational form and maturity. While these appear in many cases to have grown out of local responses as part of the general trend in England towards scaled-up primary care (Smith and others, 2013a), there has been a push from CCG leaders in North West London to develop these further, particularly in the wake of the successful North West London bid to become a Prime Minister's Challenge Fund pilot.

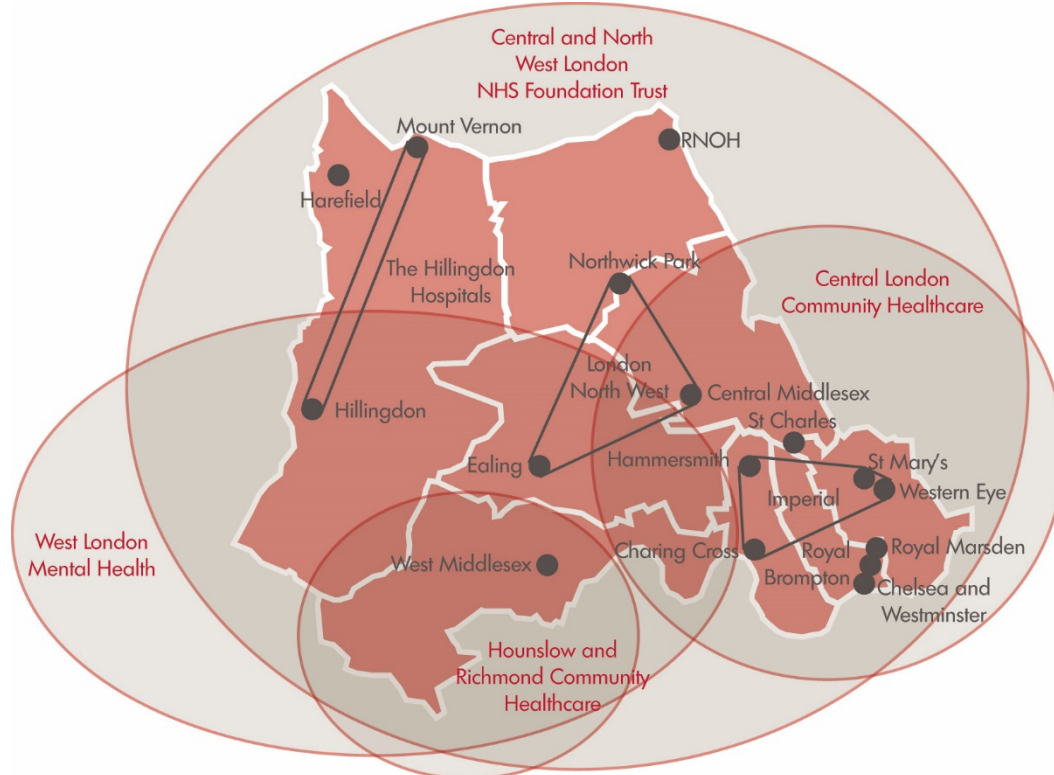### NHS acute, community and mental health providers

The main NHS providers in North West London include nine acute and specialist hospital trusts, two mental health trusts, two community health trusts and over 400 GP practices. The various trusts are mapped out in Figure 2.

Six acute trusts in North West London signed up to the integrated care pioneer bid in June 2013. These were:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Ealing Hospital NHS Trust
- Imperial College Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- North West London Hospitals NHS Trust (which also provides community health services)
- West Middlesex University Hospital NHS Trust

(NHS North West London, 2013a, p. 2).

Figure 2: Map of the North West London provider landscape covering acute trusts, and mental health and community services

In North West London there are two community health trusts, one trust that provides both community and mental health services, and one trust that provides mental health services only. These are:

- Central London Community Healthcare NHS Trust (community health services)

- Hounslow and Richmond Community Healthcare NHS Trust (community health services)

- Central and North West London NHS Foundation Trust (mental and community health services)

- West London Mental Health NHS Trust (inpatient and community mental health services)

Like the acute trusts listed above, these four community and mental health trusts also signed up to the integrated care pioneer bid in June 2013 (NHS North West London, 2013a, p. 2).

The sheer number of organisations involved in the WSIC programme is striking, as is their individual and collective complexity. Their financial positions vary greatly.[3] However, the

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3 See, for example, the annual reports of London North West Healthcare, Imperial College Healthcare NHS Trust, Chelsea and Westminster NHS Foundation Trust, Hillingdon Hospitals NHS Foundation Trust, Central London Community Healthcare Trust, Central and North West London NHS Foundation Trust and Hounslow and Richmond Community Healthcare NHS Trust.

majority are in deficit and underperformed against their planned end-of-year results in 2014/15, placing their leadership teams under considerable pressure. As we explore later in this report, it was unsurprisingly complicated, time-consuming and ambitious for leaders of the WSIC programme to engage with all these providers, both in designing the WSIC programme and then seeking to develop and implement early adopter pilot projects.

Reconfiguration of acute hospital services in North West London

Launched in January 2012, *Shaping a Healthier Future* is a large-scale programme for reconfiguring hospital-based services in North West London and shifting care into the community. It grew out of work that began in 2009 to improve out-of-hospital care and heart attack, stroke and trauma services across London (Independent Reconfiguration Panel, 2013). The strategy is based on three underlying principles:

1. centralising specialist care when necessary

2. localising care close to patients' homes where possible

3. integrating care across health and social services for people with long-term conditions and the elderly.

Following a public consultation in 2012, the programme was approved by the Joint Committee of Primary Care Trusts in February 2013. This was subject to a review by the Independent Reconfiguration Panel, on whose advice the Secretary of State for Health decided to support the programme's proposals in full (Independent Reconfiguration Panel, 2013).

One of the most important proposals in *Shaping A Healthier Future* was to reduce the number of major acute hospital sites in North West London from nine to five, concentrating certain services to develop 'centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care' (Brent CCG, 2015). Another important proposal was to develop other sites into local hospitals with 24/7 urgent care centres to treat patients with minor injuries and illness (Department of Health, 2013). This involves major changes to health services at some sites, such as the closure of the ambulance and emergency (A&E) units at Central Middlesex and Hammersmith Hospital, which took place in September 2014.

Three large-scale change, or 'transformation', programmes are running alongside acute service reconfiguration, intended to improve out-of-hospital care in North West London: the WSIC programme (described in early *Shaping a Healthier Future* documents as 'enhanced integration'), primary care transformation and transformation of mental health services.

Social care providers and the third sector

In common with the national pattern, the bulk of publicly funded social care provision is contracted out to for-profit and not-for-profit organisations. In addition, local authorities fund community groups and networks to build capacity in the community and to support care at home and localised activities that promote health and wellbeing. Again in common with the national pattern, local authorities in North West London have been managing competing demands: dealing with reductions in expenditure resulting from central

government spending plans, whilst simultaneously participating in the WSIC programme and making preparations to implement the far-reaching provisions of the 2014 Care Act with effect from April 2015 (some elements of which have subsequently been delayed; Burt, 2015).

The introduction of resource transfers from the NHS to support social and other services as a contribution by the NHS to offsetting the cuts in council spending was also intended to support integrated planning and care delivery. These transfers were increased in value through the establishment of the Better Care Fund, and the development of local plans for the allocation of the fund also provided a prompt, as well as an opportunity, to enhance joint planning and to fund initiatives in integrated care. A substantial process of review and assurance at the national level also accompanied the planning process.

Chapter summary

North West London is a diverse, populous and complex area which has in the past been considered an NHS region, for example as a strategic health authority. It is in the midst of major change to acute hospital services, as well as significant reform of mental health and primary care, and this is taking place against a backdrop of rising financial deficits within the majority of the local NHS providers, with deep cuts having been made to local government and social care (Department for Communities and Local Government, 2014).

To seek to develop better integrated care across such a large and complex area at a time of sustained austerity is bold, especially in the context of international research evidence that points to the difficulty of making integrated care work in practice, and certainly beyond smaller local pilots. We return to this issue of scope, scale and context in our discussion in chapters 5 and 6.

3. Designing the programme

This chapter sets out the WSIC programme's evolution from previous local initiatives and its bid for national integrated care pioneer status. In particular, we explore the programme's overall purpose and individual components, together with its funding and governance. We then examine the aims and process of the initial co-design phase, analysing what our evidence tells us about the approach taken and especially what worked well and what worked less well.

Establishing the programme

The evolution of the WSIC programme from previous local initiatives

One of the immediate antecedents of the WSIC programme was the Community Budgets pilot in the Tri-borough area. Community Budgets were a scheme that originated as part of the Government's 2011 White Paper 'Open Public Services' (HM Government, 2011). The paper called for a new approach to delivering public services and, in particular, to allow service providers to 'share budgets, improving outcomes for local people and reducing duplication and waste' (Department of Communities and Local Government, 2012). From October 2011 to October 2012, four pilot areas were established, one of which comprised the Tri-borough local authorities.

Shortly after being selected as a Community Budgets pilot in December 2011, the Tri-borough local authorities commissioned work together with NHS London to explore how existing approaches to integration in the local area could be scaled up across the 'whole system' of health and social care services in the three boroughs. Members of the nascent North West London CCGs' Strategy and Transformation team, known at the time as the Delivery Support Unit and situated within the North West London Primary Care Trust cluster, were involved in this, in addition to their work on the Community Budgets pilot and initiatives such as the Inner and Outer North West London ICPs.[4] Active participation in the whole systems project was also secured from the newly established CWHH Collaborative of CCGs (CWHH CCG, 2013).

Simultaneously, the business case for *Shaping a Healthier Future* – the North West London strategy for health services reconfiguration – was being developed (see chapter 2 for details of this programme). This was informed by a public consultation from July to October 2012. In tandem, the newly established CCGs were elaborating their out-of-hospital strategies to strengthen service provision in the community. Their focus built on earlier initiatives, particularly those based on the role of GPs as coordinators of care within the context of scaled-up and enhanced general practice. Examples included initiatives in

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4 The Inner and Outer North West London ICPs were large-scale projects focused on developing new forms of care coordination and planning for two key groups: people with diabetes, and those over 75 years of age. They brought together organisations from the acute, primary care, community care and social care sectors. The pilots undertook a considerable amount of work in pooling information and using an IT tool to allow for the identification of patients needing intensive case management, while multidisciplinary groups of local care providers met on a regular basis to review and plan people's care. The first year of operation of the Inner North West London ICP was evaluated by a team of researchers from Imperial College London and the Nuffield Trust; an overview of related publications is available.

intermediate care such as the rapid response and re-ablement services (STARRS) in Brent and the Community Independence Service in Hammersmith and Fulham.

As one of our interviewees from the WSIC programme team noted, the flip side of the changes implied by *Shaping a Healthier Future* was that 'there needed to be some quite radical transformation about the out-of-hospital situation' (PT2). While the strategies of the individual North West London CCGs had clearly been designed in response to *Shaping a Healthier Future*, coordination between them was less apparent. During the summer of 2012, thinking emerged among commissioners and staff in what was then known as the CCGs' Delivery Support Unit that a more coordinated, pan-North West London approach might be a better way to support local areas to deliver their out-of-hospital strategies (North West London Collaboration of CCGs, 2013a). This was accompanied by a merging of the work on the Community Budgets pilot and the whole systems project, for as another member of the WSIC programme team told us:

> At some stage there was a sort of penny drop moment… actually these are trying to do the same thing… perhaps we should bring them together. (PT7)

Preparing the national integrated care pioneer bid

Work on the core features of the WSIC programme was therefore well underway when Health Minister Norman Lamb announced the national integrated care pioneer initiative in November 2012. By the time the business case for *Shaping a Healthier Future* had been approved in February 2013, the business case for the Tri-borough Community Budgets pilot had also been produced. We were told that this led to 'a discussion about… do we move it forward with the three [CCGs] or do we move it forward more widely' (PT7). A joint commissioner workshop was held in February 2013, attended by about 50 health and social care commissioners and service users from across North West London, who indicated that they were interested in the programme as long as it did not involve a 'one-size-fits-all' approach. The proposal to put the WSIC programme forward for pioneer status was being discussed by the commissioner leads and programme team around the same time. Among several potential benefits, pursuing pioneer status was seen as a way to establish a formal relationship between the various WSIC partners and to have 'some clear commitments that everybody has to stick to and… a national spotlight that encourages you to stick to those' (PT4). Pioneer status also came to be seen as a way to 'secure central government support of NWL [North West London] plans to deliver better outcomes for patients and people who use services', as well as 'greater influence within the system to address systemic barriers' (North West London Collaboration of CCGs, 2013a).

A range of activities ensued after these preliminary discussions. Initial statements of support were obtained from all North West London CCGs and local authorities, and the commissioner leads and programme team decided that the WSIC programme should be implemented across the eight boroughs and in two stages:

1. A co-design phase, during which commissioners, providers and the programme team would work together to develop ways of addressing common challenges in enabling integrated care.

2. An implementation phase, during which these solutions would be tested out, with the intention that they would support delivery of the CCGs' out-of-hospital strategies, *Shaping a Healthier Future*, and the integration agendas of the local authorities.

The proposal for this was presented to the Collaboration Board of the North West Collaboration of CCGs in March 2013. In addition to the two-stage approach, the proposal outlined early ideas for governance arrangements; suggestions for resourcing the programme; the need for specialist consultancy support, particularly for the co-design phase due to its scale and complexity; and the desire to pursue pioneer status. At this point (and as late as June 2013; North West London Collaboration of CCGs, 2013a), the emphasis for the co-design phase was on collaboration between local commissioners and providers. Lay partner involvement was limited initially to the area of co-design responsible for 'identifying and understanding the population of the local area that would most benefit from integrated care' (North West London Collaboration of CCGs, 2013b).

Perhaps the most important development after this was the programme team's success in getting 31 partner organisations to sign up to the North West London bid, including all eight CCGs and all boroughs in North West London except for Hillingdon; ten NHS trusts and foundation trusts providing acute, community and/or mental health services; a number of academic partners and commissioning support; Health Education North West London; and NHS England. Their participation was aided by engagement events such as one in June 2013 which aimed to boost the profile of the North West London bid nationally, attended by government ministers Norman Lamb and Brandon Lewis, and involving more than 100 people from health and social care services across North West London. Both ministers visited the Community Independence Service in Hammersmith and Fulham (London Borough of Hammersmith and Fulham, 2013) after this event to see an example of a local integrated care scheme in action.

Other important activities in the run up to the pioneer bid were workshops with service users from across North West London, as well as interviews and surveys of these groups. In June 2013, for example, over 50 patients, service users and carers attended a half-day workshop, part of which focused on how they might be involved in the co-design phase and the rest of the programme moving forward (North West London Collaboration of CCGs, 2013c).

Importantly, it was during the run up to the pioneer bid that a ten-step methodology for achieving integration of services was developed by the programme team (Figure 3), and the decision made by commissioner and programme team leaders to establish five pan-North West London working groups during the co-design phase to help local areas implement this methodology (Figure 4). The decision to establish a cross-cutting workstream known as 'Embedding Partnerships' was also made during this time, its purpose being 'to support effective partnerships among professionals and with people who use services, carers and members of the local population to ensure that changes are co-produced' (WSIC Integrated Care Toolkit, 2014, p. 25). All of these activities and papers culminated in the submission of the pioneer application by the 28 June 2013 deadline.

Figure 3: WSIC ten-step process for establishing a new model of care in North West London
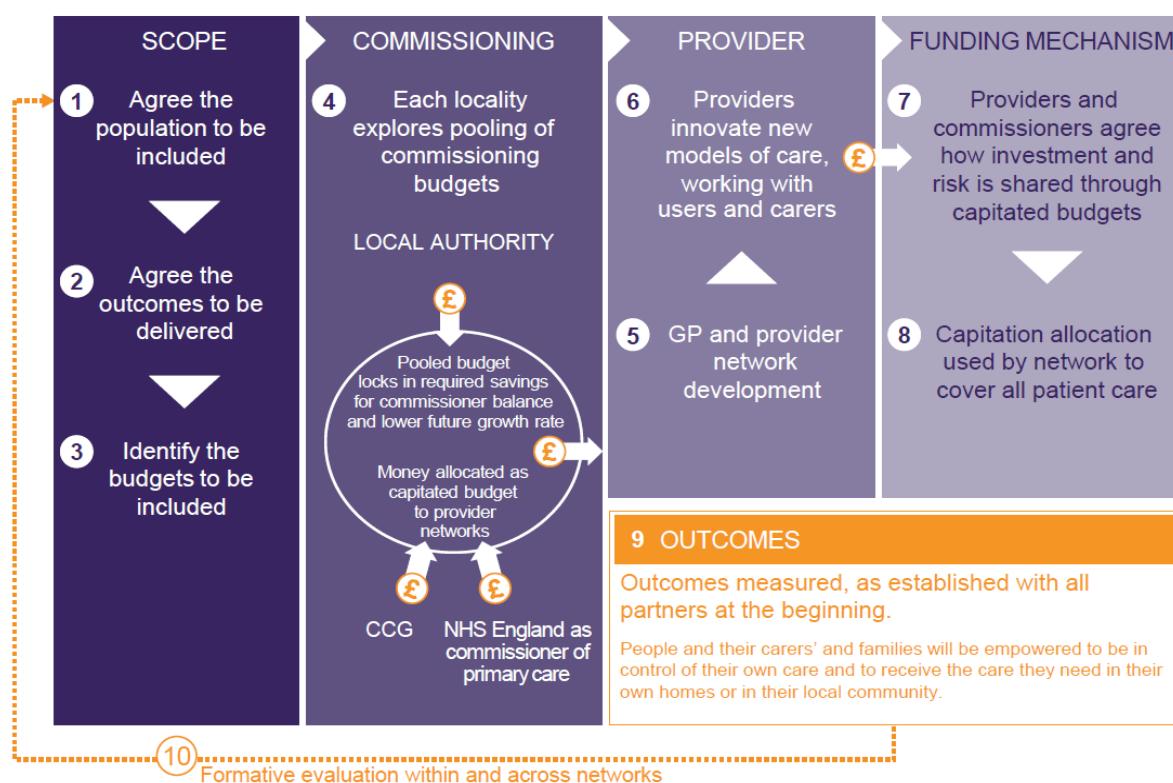
Source: NHS North West London, 2013a, p. 6

Figure 4: The five working groups during the co-design phase and the questions they sought to address
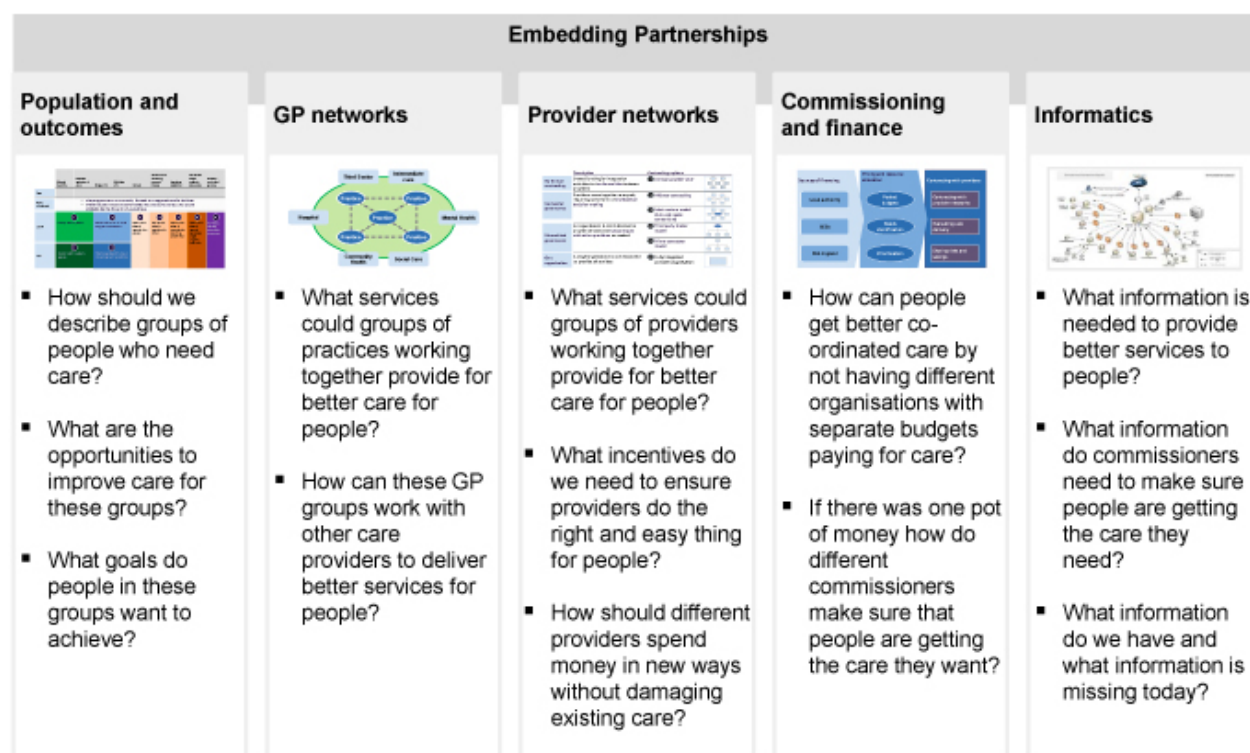
Source: WSIC Integrated Care Toolkit, 2014, p. 24

The WSIC vision and timetable

The vision of the WSIC programme as set out in the WSIC Integrated Care Toolkit is 'to improve the quality of care for individuals, carers and families and to empower and support people to maintain independence and to lead full lives as active participants in their communities' (WSIC Integrated Care Toolkit, 2014).

This is underpinned by the following principles:

- People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

- GPs will be at the centre of organising and coordinating care so that it is accessible and provided in the most appropriate setting.

- Systems will enable and not hinder the provision of integrated care, and ensure that funding flows to where it is needed most

(WSIC Integrated Care Toolkit, 2014).

As shown in Figure 5, the timetable for the WSIC programme, as set out in the North West London pioneer bid, allowed for an eight-month period of 'co-design to inform local implementation', approximately six of which would follow the submission of the pioneer bid (NHS North West London, 2013a, p. 5). Wave 1 sites (as pilot sites known as 'early adopters' were initially designated) were to be identified during the last three months of this phase, after which they would 'be ready to commence in shadow form in early January 2014' and start 'working together under "whole system" commissioning and provision arrangements to improve outcomes for the local population' (NHS North West London, 2013a, p. 10). Also of note is the intended evolution of 'central support' to 'local ownership' over the first 15 months of the project.

As described in subsequent chapters, this timetable slipped significantly over time, with implications for the programme that are discussed in chapters 5 and 6.

Governance of the WSIC programme

The governance and implementation structures designed to deliver the WSIC programme were complex, spanned multiple levels and varied in terms of their formality. They can be grouped into those located centrally at the programme office, and those situated locally at borough level and specific to each of the nine early adopter projects. This section examines the centrally located structures that were part of the overarching North West London governance framework for the WSIC programme, looking first at the formal governance arrangements and subsequently at how WSIC governance functioned in everyday practice. The governance and implementation arrangements for the individual early adopter projects are explored in chapter 4.

Figure 5: Design and implementation timetable for the WSIC programme as set out in the North West London pioneer bid
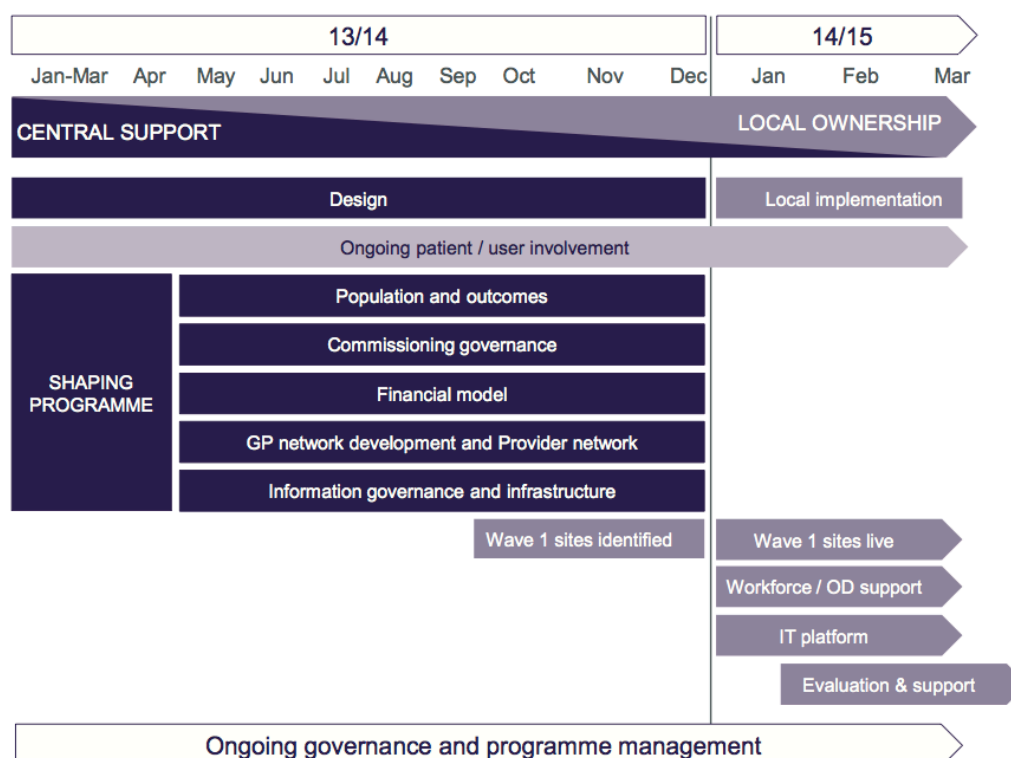
Source: NHS North West London, 2013a, p.10

Formal arrangements

Figure 6 shows the governance arrangements in place during the co-design phase of the WSIC programme. These can be divided into three categories:

1.   those formed to provide oversight, accountability and strategic direction

2.   one body tasked with providing operational support

3.   several bodies assigned either an implementation or engagement function.

Structures for oversight, accountability and strategic direction

The first category comprises the North West London Integration Board and the Programme Executive group. The formal role of the Integration Board was to oversee the WSIC programme and set its overall strategic direction, including scope, aims and timescales (WSIC Programme Management Office, 2014b). In addition to the Director of Strategy and Transformation, membership comprised approximately 50 individuals including accountable officers from commissioners, providers and local authorities from across North West London, as well as representatives from an advisory group of patients and services users (WSIC Programme Management Office, 2014a).[5] All 31 partner organisations in the pioneer bid were represented. The Integration Board was established

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5 Lay partner is the name that service users and carers participating in the WSIC programme chose for themselves.

by the North West London Collaboration of CCGs and was responsible for reporting to them on the progress of the WSIC programme (WSIC Programme Management Office, 2013a).

The Programme Executive group was established by the Integration Board 'to steer and inform WSIC programme activities, strategic direction and workstream deliverables in line with the scope, aims and timescales set out by the Integration Board' (WSIC Programme Management Office, 2014b). The group of about 20 members met at the programme office fortnightly between October 2013 and May 2014, and generally monthly thereafter.[6] Membership consisted of a broadly equal number of NHS provider and commissioner leaders, plus the Director of Strategy and Transformation, members of the WSIC programme team, several local authority representatives, and the lead for lay partner involvement (and, later, additionally a lay partner representative).[7] The GPs who attended included CCG chairs and the clinical director of the WSIC programme. Over time, attendance among the NHS providers tended to be delegated down from chief executives to clinical directors or directors of strategy, with a small cohort of senior members who had been present from the start of the programme, notably from community providers.[8]

Figure 6: Pan-North West London governance arrangements during the co-design phase of the WSIC programme
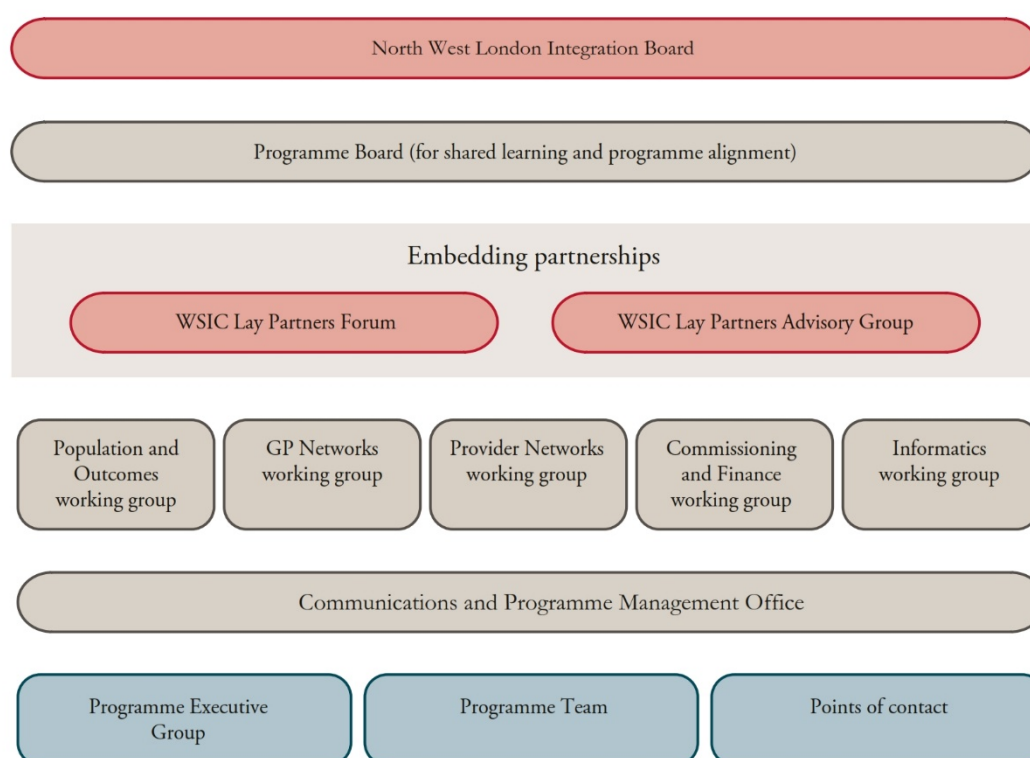
Source: Adapted from WSIC Programme Management Office, 2013a.

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6 As of the time of writing in June 2015, the pan-North West London governance arrangements of the WSIC programme were under review and no further meetings of the Programme Executive group had been scheduled.
7 Our own estimate based on attendance lists provided by the programme team.
8 Personal communication with member of the programme team in email, confirming evaluation team observations of these meetings and review of attendance lists.

Structures for operational support

The second category in the governance framework comprised the WSIC programme team, which was located at the programme office and provided highly structured programme management, operational and other support for the WSIC programme. This team was part of a wider operations unit known as the Strategy and Transformation team, which delivered a range of structures for operational support to the other transformation programmes as well as the WSIC programme (that is, acute care reconfiguration, primary care and mental health transformation). The Strategy and Transformation team consisted of NHS management staff, as well as a number of full-time external consultants and secondees from other organisations (for example, the Department of Health), and comprised approximately 50 individuals, about 13 to 15 of whom were at any one time in the WSIC programme team.[9]

Structures for implementation and engagement

The third category comprised the five co-design working groups, the WSIC Programme Board, and the Embedding Partnerships workstream with its two component parts: the Lay Partners Forum and Lay Partners Advisory Group. The five working groups were established as part of the co-design phase to address potential barriers to integrated care once at the North West London level, rather than having to replicate this work locally, or as one member of the programme team told us, 'to think about collective solutions to some of those difficult problems' (PT4). Strictly speaking, these were structures for implementation rather than governance, as they were convened by the Programme Executive to produce outputs that would enable implementation at the local level whilst providing these local activities with an overarching conceptual framework.

Another group tasked with more of an implementation function was the Programme Board, which was set up to facilitate discussion across the five working groups, as well as to communicate a single, shared understanding of the purpose of the WSIC programme (WSIC Programme Management Office, 2013a). It met on two occasions, in November 2013 and January 2014. The group of about 60 members included the co-chairs of the five working groups, lay partners and others from the Embedding Partnerships workstream (described below), and senior managers from many of the organisations represented on the Integration Board (WSIC Programme Management Office, 2014a).

Lastly, the cross-cutting workstream called Embedding Partnerships had both a stakeholder engagement and a governance function. According to its terms of reference, the workstream 'supports lay partners to come together with professionals and co-produce integrated care, ensuring that the person remains at the heart of any plans throughout' (WSIC Programme Management Office, 2014f). It consisted of a Lay Partners Advisory Group and a larger Lay Partners Advisory Forum.

The Lay Partners Advisory Group comprised 15 to 20 members from all eight boroughs of North West London. Meeting every three weeks, it considered and advised on all aspects of the WSIC programme from service user and carer perspectives. A range of training was provided to members of the group, including workshops on facilitating meetings and

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9 Personal communication with member of the programme team.

learning how to interact with clinicians and senior managers. Lay partners volunteered all of the time spent on their work for the programme, but expenses were paid for travel to meetings.[10]

The Lay Partners Forum had approximately 120 members recruited between November 2013 and March 2014. Its members include service users and carers from all eight boroughs of North West London, representing each of the population groupings within the WSIC model of care and the protected characteristics of the Equality Act. The forum met quarterly and aimed to hold the Lay Partner Advisory Group to account and 'ensure the Advisory Group are able to represent a breadth of real life experiences and services' (WSIC Programme Management Office, 2014f). It served both as a sounding board for recommendations made by the Advisory Group and as a pool from which both the Advisory Group, programme team and early adopters could access lay partner support as needed.

A distinctive feature of WSIC programme governance was the inclusion of lay partners as full members in each of the bodies in the WSIC governance structure, with the exception of the programme team. The implications of such extensive lay partner involvement are discussed in chapter 6.

WSIC governance in practice

In everyday practice, governance and strategy at the North West London level were driven during the study period primarily by the North West London Collaboration of CCGs, the Programme Executive group and the programme team. In other words, the drive was very much coming from NHS management and organisations, with less evidence of strong impetus from local government and other partners. As one of our interviewees pointed out to us in February 2015:

> *Although it was a very co-designed programme it's probably fair to say in the early days right through to autumn last year if you asked people from other organisations with the exception of the third sector, they would probably have said it was a clinical commissioning group, commissioner-driven conversation, even though they were full partners.* (LP3)

A rough breakdown of the total number of times representatives of a particular sector attended a Programme Executive meeting between October 2013 and 15 May 2015 indicates that community and/or mental health trusts had the greatest number of attendances (n = 61), followed by acute providers (n = 39), CCGs (n = 35), lay partners (n = 29) and local authorities (n = 26). A total of 25 Programme Executive meetings were held during this period, and at some meetings there were multiple attendees from any given sector.[11]

Moreover, it was the Programme Executive group, and not the Integration Board, which served in practice as the highest level of sign off before strategic papers or other proposals were submitted to the Collaboration Board of the North West London Collaboration of CCGs.[12] In the meetings we observed of the Programme Executive group, papers and

10 Confirmed through personal communication with lay partner member of the Lay Partners Advisory Group.
11 Personal communication with member of the programme team.
12 Personal communication with member of the programme team.

proposals of this nature had usually been generated by the programme team, often with input from bodies such as the working groups, the Lay Partner Advisory Board, and the Integration Board. Our observations of Programme Executive group meetings and review of notes from the Integration Board indicate that detailed discussion of the scope, aims and timescales of the WSIC programme typically took place in the former rather than the latter.

The Programme Executive group did not have formal decision-making powers, and therefore had no voting arrangements in place. In the meetings we observed, decisions were reached by consensus, often after in-depth discussion among the members. At times, the Collaboration Board of the North West London Collaboration of CCGs delegated responsibility to the Programme Executive group, for example allowing it to choose when resource would be released from pooled CCG funds to provide each of the early adopters with funding for a project manager.

Like the Programme Executive group, the Integration Board had no formal decision-making powers or voting arrangements. Although it was asked on occasion to endorse proposals which had been decided upon by the Programme Executive, our review of notes from the four meetings of the Integration Board suggest that this was largely a formality. Unsurprisingly, considering its size and the infrequency with which it met, the Integration Board appears to have served primarily as an inclusive forum to strengthen relationships among leaders across North West London, and to keep all the partners in the pioneer bid abreast of latest WSIC programme developments. The last meeting of the Integration Board was the launch event of the WSIC Integrated Care Toolkit on 15 May 2014.

How the WSIC programme is funded

The WSIC programme is funded as part of the North West London Financial Strategy (2014/15 to 2018/19), which is a collaboration between the eight North West London CCGs and has been used to support large-scale transformation programmes across the sector. The costs of the WSIC programme are: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support. Further details of this expenditure are provided in Box 1.

<div style="background:#555; color:white; padding:4px;">Box 1: North West London Financial Strategy</div>

"The North West London Financial Strategy (2014/15 to 2018/19) is a collaboration between the eight North West London CCGs and has been used to support large-scale transformational programmes across the sector. Resources are pooled to enable the strategy to support three clear objectives, the first of which includes covering the design, planning and implementation costs of large-scale change ('transformation') programmes across North West London, including the WSIC programme.

In 2013/14, strategy funding for the WSIC programme amounted to £6.4m, which was split between pan-North West London support and implementation (£3.7m), and direct CCG funding for local support (£2.7m). In 2014/15, strategy funding for the WSIC programme amounted to £8.5m, again split between pan-North West London support and implementation (£5.5m), and direct CCG funding for local support (£3.0m). At the end of this study, 2015/16 strategy funding consisted of £10m, with a greater proportion allocated to direct CCG funding (£6.75m) compared with pan-North West London support (£3.25m) – to reflect the shift towards local ownership and direction of resource.

The majority of the pan-North West London resource each year was allocated to bringing a wide range of specific, specialist expertise to bear on the barriers to integration (£3.5m in 2013/14 and £4.4m in 2014/15), as well as a comprehensive programme of co-design incorporating the input of over 200 representatives (staff and service users) from across health and social care, resulting in the North West London Integrated Care Toolkit. The technical expertise has included input on:

- supporting the early adopters through initial intensive work to develop new models of care and the development of a step-by-step handbook
- building informatics capability, including a range of tools and system developments, and the information governance approach and infrastructure required to support it
- designing a new approach to funding health and social care based on a capitated methodology
- developing legal guidance and template contracts to support new provider models and ways of commissioning to support integration
- the design and delivery of an organisational development programme and an extensive programme of co-design across the North West London system
- ensuring that national and international best practice is brought to bear on the North West London model."

The results of this work are available.

[Publicly available information provided by the North West London Collaboration of CCGs]

This evaluation was not commissioned to conduct cost-effectiveness studies of any aspect of the WSIC programme and is not in a position to provide an assessment of the actual or potential value for money secured by investment in the programme, including its support from management consultancy.

Developing programme outcomes

The pioneer application, submitted in June 2013, contained numerous references to outcomes. For example, step two of the ten-step implementation framework described its 'overall aim [as being] to improve outcomes for service users and to explore whether this can be done at more sustainable cost' (NHS North West London, 2013a). The same source stressed that outcomes and outcome measures should be defined 'from the outset' through a process of co-design, and that 'the overall outcome we seek is to ensure that our local

populations are living longer and living well'. In October 2013, it produced an 'integrated care value case' setting out a wide range of benefits the project would produce for four categories of stakeholder: commissioners, users, the public and its workforce. These benefits included substantial reductions in emergency admissions (up to 15 per cent), A&E attendances (up to 30 per cent) and emergency inpatient days (unspecified), as well as better value for money and improved patient care (NHS North West London, 2013b).

These benefits appear to have been indicative of the programme's aspiration and direction rather than an agreed statement of expected outcomes. When the co-design process got under way, 'Population and Outcomes' was one of five working groups to be established and to produce materials for the toolkit. The working group reviewed a number of outcome frameworks and summarised them into five domains:

- Quality of life
  - Personal and social goals
  - Prevention

- Quality of care
  - Safety
  - Effectiveness
  - Service user experience of care

- Financial sustainability

- Professional experience

- Operational performance.

The WSIC Integrated Care Toolkit emphasised that the first two domains were the most important because 'the most important perspective is the well-being of the person who is receiving services' (WSIC Integrated Care Toolkit, 2014, Chapter 5).

Following the toolkit's publication, the programme team – together with input from lay partners and four focus group sessions with service users and carers – developed a short series of person-centred outcome measures during autumn 2014 for each of the five domains, focusing on older people with long-term conditions.

From February 2015, the team engaged with early adopters and others in North West London about the proposed outcomes framework and the design of dashboards, which will enable visualisation of how outcomes are being met and ideally drive improvements to care. This work indicated an emerging consensus around the benefits of a high-level consistent outcomes framework for the WSIC programme, based on a limited number of outcomes and metrics.

As will be evident from this account, the WSIC programme has attached priority to defining outcomes and metrics through co-design processes, which has included some intensive work with lay partners, service users and carers together with staff in the early adopters. A series of dashboards has now been developed. However, they were not finalised and available for use at the end of our fieldwork. It also follows that specific outcomes had not been driving the development of early adopters except where the latter were developing their own. As a result, the programme has been working towards a more

generalised, but clearly articulated, set of outcome statements rather than targets. This approach may have been sufficient in the early stages, but it is increasingly urgent to have agreed measures at the level of early adopters and the programme as a whole in order to provide assurance about the achievement of the programme's quality improvement and cost-effectiveness aims.

The co-design process

Aims and process of the co-design phase

The first stage of the WSIC programme was a period of co-design, organised and run by the programme team with considerable consultancy support from October 2013 until late February 2014. It was highly inclusive in its philosophy, bringing together almost 200 health and social care organisations, as well as patients, service users and carers, from across North West London, to develop solutions to common challenges to the design and delivery of integrated care. These challenges had been identified by the programme team in the run up to the pioneer bid and the five working groups formed were (see also Figure 6 on page 23):

- Population and Outcomes

- GP Networks

- Provider Networks

- Commissioning and Finance

- Informatics

The idea was that solutions generated by these groups would be piloted locally by the early adopters, who could experiment with new ways of working and models of care. The co-design phase culminated in the launch of the WSIC Integrated Care Toolkit on 15 May 2014, which provided an overall framework for the design, development and implementation of the early adopter schemes.

One important aim of the co-design phase was to allow a balance to be struck between a push from the top for standardisation and consistency, and a pull from the bottom for local ownership. In particular, the programme team was keen for the WSIC programme to be seen as a joint piece of work between themselves and the rest of the local health and care system, and not something that was superimposed in a traditional NHS top-down way. One member of the programme team told us that:

> *The co-design process came about because we were clear that this was only going to work if it was a journey that everyone came on, but we also had to strike the balance between doing some of the design thinking once that local areas could then hang their own initiatives off.* (PT2)

Another important aim of this initial phase of the programme was to ensure that co-design would happen horizontally and be as inclusive as possible, so that the WSIC programme would be designed and owned, not only by the NHS, but by a wide range of interests, particularly social care. One member of the programme team described how the working groups were co-chaired, or 'fronted by someone from the CCG and by someone from the

local authority… It was a tangible demonstration that people were working together on this' (PT4).

The same respondent noted how the programme team had 'spent a really long time trying to make sure the membership of the groups was quite diverse and reflected the different partners as well' (PT4). Indeed, in the North West London pioneer bid, the plans for stakeholder involvement are described as comprising engagement with service users, families and carers; the workforce; and commissioners and providers of services across the public, independent and third sectors (NHS North West London, 2013a, p. 8).

Another member of the programme team, interviewed in April 2014, described how the co-design phase had also initially functioned as a way to ensure that the five North West London boroughs outside of the Tri-borough would feel included. This respondent told us how the programme team had initially presented the WSIC programme very much as a Tri-borough model, but had then 'pulled back and said, no, no… this is about a co-design period… So that was where the co-design term came from' (PT7). Soon, however, this was 'no longer an issue', to use the words of the same respondent, who added that 'now the co-design is much more how you work with lay partners than it is… saying we're not trying to impose Tri-borough's model' (PT7).

Indeed, the lay partner element of the co-design phase gradually became its dominant theme. Early WSIC plans describe the lay partner element in broad terms, noting how, in addition to the programme team and specialist consultancy support, the co-design phase would be driven by 'commissioner and provider representatives… together with patient and carer representatives' (North West London Collaboration of CCGs, 2013b). In response to the decision to apply for pioneer status, later plans expanded upon this role, describing how the programme team aimed 'to develop with patients, service users and carers a common [North West London-wide] framework of what integrated care means locally for patients/service users and what measures the programme should use to evaluate successful delivery of patient-centred care' (North West London Collaboration of CCGs, 2013c).

This framework is described in the same document as 'the underpinning ethos for the WSIC programme'. This development is perhaps unsurprising considering that one of the expectations of prospective pioneers set out by the National Collaboration for Integrated Care and Support was for local leaders in pioneer areas to 'engage with local people, patients and people who use services to hear their experiences and work with them to find co-produced solutions'. A comparison with other national integrated care pioneers, however, suggests that the extent of lay partner involvement in the WSIC programme appears to be unusual, if not unique (Erens and others, 2015). The implications of this are discussed in chapters 5 and 6.

Outputs of co-design

Each of the five working groups met six to eight times between October 2013 and late February 2014, and produced a set of working documents around their particular 'knotty problem'.[13] Content for this phase was developed by external consultants, chiefly McKinsey & Company, in partnership with the programme team. The programme team

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13 Personal communication with member of the programme team.

also provided extensive administrative and project management support for this phase, as well as meeting facilitation. In the main, participants included lay partners, health and local authority commissioners, NHS providers from the acute, mental health and community health sectors, and a substantial number of people from management consultancy and the programme team (North West London Collaboration of CCGs, 2013d).

The most tangible output of the co-design phase was the WSIC Integrated Care Toolkit, a 298-page volume summarising the discussion documents developed by each of the working groups and accompanied by an extensive set of supporting materials. An online version of the toolkit was also created to make the contents easier to access and to allow them to be amended in the light of experience from the early adopters as they moved through the implementation phase.

The idea of creating a toolkit evolved from early thinking by WSIC leaders about using a period of co-design to create a 'suite of solutions, tools or products for local areas to then implement locally to fit with the delivery of their OOH [out-of-hospital] strategies, *Shaping a Healthier Future* and local authority integration agendas' (North West London collaboration of CCGs, 2013d). While the pioneer bid itself does not mention a toolkit, by July 2013 the WSIC programme team had proposed to the CCG Collaboration Board the development of such a product 'as the output of the co-design phase to inform implementation' (North West London Collaboration of CCGs, 2013d). The current format of the toolkit, however, appears to have emerged during the co-design phase, which in the words of one member of the programme team had come to be seen as 'huge and quite unwieldy', leading the working group participants to push the programme team quite strongly to find a format for the material that would allow it to be more easily used in subsequent phases of the programme (PT4).

Other outputs from the co-design process reported to us in interviews were less tangible than the toolkit, yet were deemed to be significant by respondents. These included the creation or strengthening of working relationships and social capital; and, tied to this, the formation of a core group of ambassadors, or 'evangelists' (CG10), for the WSIC programme who would bring their enthusiasm back to the local level. Some interviewees reflected that these process benefits were, in fact, more important than the toolkit, and expressed concern that they might be overshadowed by it with the result that co-design might be seen as a completed phase of the programme rather than a continuing process (for example, PT1, FA3, CG16).

Assessing the approach to governance and co-design

Leadership, enthusiasm and commitment

The WSIC programme has been characterised by strong and effective leadership, both in the programme team and the various bodies within its multi-layered governance structure. This was emphasised by many of the people interviewed, and is underscored by our survey of early adopter steering committee members, 67 per cent of whom agreed that the programme had clear leadership and 74 per cent of whom felt that the WSIC programme had clear management and governance structures.

The programme team in particular was seen as giving positive energy and influence to the WSIC programme, as noted by one local authority respondent commenting on the co-design phase:

> *I really can't fault Thirza [Thirza Sawtell, Director of Strategy and Transformation, North West London Collaboration of CCGs] and her team in terms of their determination and persistence in trying to make sure this is jointly owned and managed, and isn't what we would regard as traditional top-down NHS, and she is working really hard, which we do appreciate, even if we don't always know how to respond.* (LA3)

An important ingredient of success for the WSIC programme, according to our interviewees, was the influence and credibility of key senior figures, many of whom had worked together on initiatives such as *Shaping a Healthier Future*, the Tri-borough Community Budgets pilot, or the Inner and Outer North West London Integrated Care Pilots. One CCG respondent told us that there were: 'a number of different people leading the system in North West London who are by nature pioneering and strategic and full of energy, and… they're helping to create that platform for change' (CG3).

There was, however, a clear intention on the part of programme team to go beyond this and harness the enthusiasm and experience of a wider base of managers and clinical leaders, for example those who had participated in the earlier ICPs. As a member of the programme team emphasised:

> *We tried to make sure that the people who had been and still are leads in the ICPs are embedded in all of those co-design groups, so that we make sure that their views and learning were captured as part of the co-design phase.* (PT2)

Our research suggests that they were largely successful in harnessing the enthusiasm of this wider group. In our survey of early adopter steering committees, 77 per cent of respondents indicated that they had been involved in the earlier ICPs, 59 per cent that they had chaired or been a member of a working group during the co-design phase of the WSIC programme, and 46 per cent that they had done both. These findings indicate that there was clear continuity in leadership, not only between the ICPs and the co-design phase of the WSIC programme, but well into the design of the early adopter projects. As noted in chapters 5 and 6, however, changes to the leadership of the programme near the end of the evaluation period were seen to have weakened the programme's strategic management capacity and had become a cause for concern.

Stakeholder involvement

The approach to the co-design working groups

Most respondents involved in the co-design phase spoke approvingly of the inclusive approach taken to the working groups. Having co-chairs, for example, was felt to have worked well in ensuring that health and social services were both at the table and owned the outcomes (for example, PT4, CG10, LA5). We were also told about the impressive efforts of the programme team and their consultancy support to involve stakeholders from health and social care, as well as lay partners, in each of the groups and ensure they had an equal voice.

One local authority officer reported that the hierarchies in these groups were largely flat, and that this had facilitated conversations, emphasising that there had been 'an absolute focus on co-production and absolute focus on the equality of input' (LA10). The same respondent added:

> *One of the things you find operationally and locally is this perceived hierarchy, GPs are more important than social workers… I felt what was really strong in the way McKinsey ran the sessions I was involved in, and the way that the Whole Systems groups are structured, is that absolutely isn't the case. There is absolute equality and I think that's fundamental to the success really.* (LA10)

A small number of interviewees, however, were more sceptical of the approach taken to the working groups. One participant felt that the facilitators 'clearly had a vision and they have stamped that vision all over… When you're badging something as this is a co-production and then it clearly is not… that to me is very concerning' (HP8). Another respondent, from a local authority, noted that:

> *There was no attempt… to close down those discussions… somehow it was, 'yes, all of those things, but we're going to do this anyway' – because, in a sense, the whole programme was based on that thesis: that if you change the way the funding flows, then you're going to change how people do things.* (LA14)

Overall these comments suggest that the programme team faced a delicate balancing act between facilitating co-design and convincing participants to adopt the different elements of the WSIC ten-step approach to implementing integrated care, such as capitated budgets, 'accountable care partnerships[14] and GPs as coordinators of care, which were core to the toolkit. As one NHS commissioner noted:

> *Taking lots and lots of people on a journey of what provider governance and commissioner governance might look like and the different options and asking them to choose what they thought the best one was likely to be without telling them in advance … And I think, if you'd sat in a room, you would have worked out that the joint venture model was the one that's most likely to be effective. But we didn't pre-empt any it: we just played it all out from the beginning.* (CG10)

The mostly affirmative comments we heard from our interviewees about the co-design phase, as well as key stakeholders' largely positive views on the toolkit (see page 39), suggest that the facilitators of this phase were successful from the participant perspective in finding the right balance between facilitating co-design and top-down solutions. However, as will be discussed in greater depth in chapter 4 (page 46) and chapter 5 (page 81), our research picked up concerns around the idea of local ownership which suggest that the co-design phase may not always have succeeded in producing a sufficient breadth and depth of ownership of its outputs. The most outspoken voices in this regard came from participants in the local working sessions which took place from early April and mid-May 2014, following the co-design phase, to begin detailed work on developing the early adopters' models of care.

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14 Accountable care partnerships (similar to accountable care organisations) are groups of providers that come together to share responsibility for providing the care required by a defined population group. Capitated budgets are one way to remunerate such groups of providers.

The cost of an inclusive approach

The inclusive approach of the WSIC programme was appreciated and supported by our respondents, but some also recognised that it had its downsides. Our local authority respondents in particular told us that they lacked capacity to attend such a large number of meetings, a consequence not only of the co-design phase, but of the overall number of transformation programmes in North West London (LA0, LA8, LA10, LA16, LA22). Concerns were raised in this context about the opportunity costs of inclusion and involvement, which were especially high in the current financial environment.

Interviewees from different sectors suggested that improved signposting of meetings would have allowed them to use their time more effectively, as summed up by a local authority officer:

> *The diary is absolutely jammed with [meetings]… Because there's this spirit of co-production… so maybe there could be an approach that's a little bit more thoughtful about the engagement of different stakeholders at different periods, and that might cut down a little bit on the volume of activity. Everything has got risks though: if you did that, people then worry that things are being decided without you in the room.* (LA8)

Another respondent from a local authority said that they were sometimes happy to have the co-design working group meetings go ahead without them because they agreed with the direction of travel and were being kept in the loop (LA0).

The rapid pace of the co-design phase and the large number of meetings also meant that the same people could not make all of the dates across a workstream – 'there was that level of churn', as one local authority officer pointed out. As a consequence, this respondent added, debates needed to be 'rehashed', which 'slowed up the work of the group' (LA10). Another local authority respondent similarly observed at an early point in our data collection that 'there is a bit of an issue about ownership because many meetings were set up with wide representation and people struggled to get to it' (LA9). This issue is discussed in greater detail in chapters 4 and 5.

Other respondents, including lay partners, saw a risk that meetings and workshops might become an end in themselves. When we asked our interviewees whether comments they had made about their co-design working group reflected the experience of people in other groups, we often heard that they were uncertain as there had been little or no sharing between them. One interviewee described this, for example:

> *Another thing that concerned me, that you've got these groups running in parallel and yet the interdependencies of those groups is massive… and we we're told 'oh don't worry, we're sharing the information from each group with the other groups'. I never heard information from other groups… It just seemed odd that you had these parallel groups moving forward but without adequate information sharing and... without congruency.* (HP8)

As discussed in chapter 4, this inward-looking focus on process has been a common theme throughout the WSIC programme and may have hampered sharing between local actors.

Engagement of social services and mental health

Despite capacity issues, local authority engagement with the WSIC programme during its co-design phase was clearly evident, driven by a small core of senior adult social services staff from several, though not all, North West London boroughs. Respondents from all sectors spoke positively about this engagement, alongside that of mental health and community services. The following comment by a CCG chair was typical of this:

> *Mental health has been absolutely brilliant… really on the table from day one in a very proactive way… So have social services. I would say certain social services more so than others, but people on the ground at social services have been very, very supportive.* (CG8)

Interviewees from all sectors, however, raised concerns about whether the engagement of social services could be sustained under current financial constraints. Similar concerns were voiced by and about mental health and community trusts, given that they are on block contracts and could end up bearing an increasing burden of involvement in the WSIC programme with little or no extra investment to gain – echoing concerns that had already been voiced during the implementation of the Inner North West London ICP (Curry and others, 2013). An interviewee from an acute trust spoke of the risk involved in moving 'away from PBR [payment by results[15]] toward block contracts' and how this involved 'taking a risk on activity… doing more and more for no income – that is not sustainable' (HP11).

Gaps in stakeholder involvement

Third sector

There were clear gaps in the involvement of third sector providers in the co-design phase, which some respondents at the time felt might be a barrier going forward. It should be noted that the involvement of the third sector was likewise a concern in the evaluation of the Inner North West London ICP (Curry and others, 2013). Among those interviewed before August 2014 who spoke about third sector involvement in the co-design phase, there was a consensus that the programme would have benefited from bringing in the third sector more strongly from the beginning (CG11, HP16, LA6, LA8, LA10, LP4, PT3, PT5, PT4, TS2). In particular, concerns were raised that ownership of the programme by local communities would be more difficult to obtain without sufficient voluntary sector involvement (LA8, HP16). One respondent from the sector felt that its important strengths were not being tapped into, citing for example greater business experience and less hierarchical structure, or an ability to draw upon the resources of volunteers and combine these into something strategic (TS1).

As discussed in chapter 4, our research suggests that this gap may have been partially addressed by some of the early adopters in the subsequent implementation phase, indicating that the local level may be the more appropriate (or, rather, more natural) level of engagement for NHS organisations with third sector providers (see page 53).

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15 Payment by results is a system whereby providers are paid for each patient seen or treatment given, taking into account the complexity of the patient's health care needs. Payment is agreed under a pre-defined tariff. The system is based in part on what are internationally known as 'diagnosis-related groups' or 'healthcare resource groups'.

Frontline staff and GPs

Our research also revealed a relative absence in the co-design phase of frontline staff, including social workers and community nurses – a gap which persisted through the remainder of the evaluation period.

Additionally, one interviewee suggested there had been 'potentially not enough GPs' in the GP Networks working group, and that some of those who were involved 'had roles elsewhere in the system' (CG3). This aligns with a more general observation made by several interviewees that they could identify a core of GP leaders, usually members of the CCG governing body, who were dedicated to the programme, but were uncertain about the buy-in of the wider group of GPs (for example, CG24, FA3, LA0).

When asked about the definition of co-design, for example, a respondent involved in facilitation of the programme argued that:

> *The working group was fine, but I'm not sure that's co-design. It didn't really involve… enough testing out on the ground with the ordinary Joe Soap GP who is struggling with X, Y and Z.* (FA3)

The same respondent felt that, instead, 'there should have been more of a kind of diagnostic engagement that informed the co-design phase, and I didn't see much of that'

One CCG leader described why they felt that securing this more extensive ownership was essential:

> *The quiet care planning and change of approach by GPs is what makes the leadership difference: I think it's more quiet hearts and minds, because in order for it to work you do need the five per cent who are wanting to stand up and say 'This is marvellous and we're doing this and doing that', but actually, in order for it to work, we've got to get the very quiet people who just want to do a normal job and make it part of their normal job.* (CG7)

The involvement of GPs and GP networks in the early adopters is described in greater detail in chapter 4 (page 53), and a discussion about the role of organisational development in addressing these and other issues associated with the depth and extent of preparedness for transformation change can be found in chapter 5 (page 81).

Acute providers

Lastly, while acute providers were clearly involved in the co-design phase in terms of attendance at the WSIC working group sessions, some of our interviewees questioned whether attendance in such sessions constituted true engagement. For example, one of our interviewees from the acute sector told us that some of the acute trusts in North West London were tied up in their own organisational pressures and had 'hoped that this is like a mosquito – you know, it's very annoying and it's buzzing in your ear all the time, and you can't ignore it … but hopefully it will fly away… and leave you alone' (HP2). Others commented that acute providers had lacked ownership of the programme and been 'passive', despite the large impact that plans for shifting more care into the community might have on them (for example, TS2, LA7). Another expressed concern that acute trusts might only be interested in taking part in the programme if they could take on the role of prime contractor[16] in provider networks (HP3). This tension was to some extent played out

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16 Prime contractor is a procurement model where the commissioner has a single contract with one organisation, and the single organisation is then responsible for establishing and managing any sub-contractors.

in the two early adopters in Hammersmith and Fulham, and in the relationship between the Imperial-led Community Independence Service and the Central London/Westminster early adopter (see chapter 4).

Lay partner involvement

The co-design phase entailed an important and increasingly appreciated role for lay partners. Our interviews reveal, however, that there had initially been some doubts among providers, NHS commissioners and some members of the programme team about extensive lay partner involvement. One respondent from the programme team told us that 'some quite senior people' felt it would be necessary 'to dumb down the content… if service users are involved'. They added, though, that 'that's really not been the case… and I think that's been… quite edifying for loads of people' (PT4).

However, such doubts were reported to have been largely replaced by enthusiasm at the end of the co-design phase. For example, one CCG interviewee said:

> *It's fantastic. I don't think I've seen engagement or enthusiasm quite like it, and I've been in the NHS for about 13 years… It's one thing that has been really successful… to design it with that at its core, absolutely the right thing to do.* (CG3)

In fact, lay partner involvement in the WSIC programme was universally seen to have made a positive contribution by the time of our initial interviews in March/April 2014. The reasons for positive views like this varied significantly, however. For instance, a number of commissioners and providers said that by keeping everyone focused on what is best for the patient, the lay partners had helped flatten hierarchies and status distinctions between professionals such as GPs and social workers. Others, such as an NHS commissioner involved with the programme, said that having lay partners at the table helped different stakeholders discuss thorny issues about topics such as governance and finance:

> *My reflections are [that] patients make the world of difference and people behave much better because of it… It's very hard to argue against what the patients want, since that's what we're all here for.* (CG17)

Some interviewees and respondents to our survey of early adopter steering committees described the lay partners as an additional and different source of challenge to clinicians, managers and others. They cited instances of lay partners questioning why professionals were not being bolder or more radical, or asking them to clarify their points and use less jargon (for example, PT2, CG3). Indeed, we observed lay members making important contributions of this nature in a range of meetings at the pan-North West London and local levels. We also observed lay partners raising concerns with commissioners, providers or members of the programme team about various aspects of the programme, which in almost all cases were treated seriously and taken up in further discussion with the wider group.

The impact of the lay partners on the use of clearer language is particularly striking when it comes to the toolkit, which has clearly benefited in terms of accessibility from an emphasis on plain, straightforward English compared with the working group outputs on which it is based.

Several of our interviewees and respondents to the early adopter steering committee survey felt that the lay partners had an important role to play in raising awareness of the WSIC

programme in the community (for example, LA8, HP16, TS2). In fact, an early aspiration of the programme was to have lay partners in each of the early adopters who would reach out to their local population and ensure that the changes being planned would make sense locally (LP1). As described in chapter 4, this had not been realised by the time of writing in June 2015, and the level of influence and involvement of lay partners seen in the co-design phase does not yet appear to have been fully mirrored at the local level.

The WSIC Integrated Care Toolkit

Building and strengthening working relationships

A common view among respondents from all sectors was that working relationships had been formed or strengthened during the co-design phase through the production of the toolkit. A lay partner who was heavily involved in all stages of the programme told us:

> *It's strange that something like that can bring everybody together, yes, and it's proving invaluable, the relationships… The relationships that were developed during that stage I think are key to making this work.* (LP5)

A respondent from the third sector described the value of these relationships from the perspective of their own organisation, saying:

> *Being involved in that production of it was really important to me. The conversations that I have with people are really useful. For me actually having access to a range of people in North West London has been really, really useful… my learning from this has been colossal.* (TS2)

Positive statements such as these among our interviewees are underscored by the findings of our survey of early adopter steering committee members. In the survey we asked respondents if the process of creating the toolkit had changed their relationships with colleagues. Of the 57 respondents who said that they had been involved, 62 per cent felt that their relationships with colleagues had improved as a result. Only one person said the relationships had become 'somewhat worse'. Positive free text comments emphasised the inclusive and democratic approach to the working groups, the breadth of stakeholder involvement during the co-design phase, and the usefulness of improved relationships going forward.

One senior respondent involved in the co-design phase described how the social capital developed during the production of the toolkit had spread beyond the core group of those involved in the co-design process:

> *The social capital that came out of it was spread across eight CCGs… the conversations that we had when co-creating it have probably rubbed off on each of themselves and we take it back to wherever our patch is.* (CG16)

These less tangible and informal benefits from the process of working alongside partners to complete a common task seem to have been a significant aspect of the process of co-design and helped establish its collective identity and purpose. The extent to which the enthusiasm and insights generated through such involvement were cascaded to local level is discussed in chapter 5.

Usefulness of the toolkit in the design of early adopters

Among our interviewees, there were some early concerns as to how far the early adopters would actually use the toolkit (for example, CG16, HP2, LP2). As our research indicates, however, these appear to have been unfounded. Three quarters of the respondents to our early adopter steering committee survey in November 2014 felt that the toolkit had been helpful in the design of their early adopter project. In their free text answers, survey respondents indicated most frequently that they had used the toolkit as a source of advice and guidance, for general background information, and to achieve consensus around local WSIC programme areas. When interpreting these findings, however, it must be kept in mind that at the time the survey was completed none of the early adopters had yet had the opportunity to test out the usefulness of the toolkit in terms of data sharing or finance.

The reaction to the toolkit among our later interviewees was generally positive, in line with the findings of our survey. One acute provider we interviewed in November 2014 reflected that the toolkit had been a useful summary of discussions in the working groups:

> *Yes but actually having that then fed back by the McKinsey team and all the central [i.e. programme] team… I thought it was very helpful to gather that together… and it came back in a very constructive and easily digestible format… and we've used that.* (HP7)

This was echoed by a local authority respondent who had been involved as a working group co-chair during the co-design phase:

> *So it's locally owned, but strategic and outside of organisational boundaries and focused on people means that when we're doing things locally, we are always referring to things.* (LA10)

The same interviewee added how they and CCG colleagues 'almost use it as the arbiter' and 'to broker difficulties', which is a similar role attributed by a number of our interviewees to the lay partners involved in the programme, as noted above (LA10).

Not everyone we interviewed was positive about the toolkit. One local authority respondent pointed out that the call for expressions of interest had been made before the toolkit had been published and circulated, which they noted 'seemed to almost negate the point of the toolkit' (LA14):

> *They're saying now, 'Well, we'll use the toolkit in doing the business cases in the next phase' and everything else. But it just felt odd to me that you wouldn't use the toolkit more to actually crystallise the ideas around the early expressions of interest.* (LA14)

Several other respondents, including the chair of one CCG, also felt that the timing of the toolkit's publication could have been better aligned with the transition from the co-design to the early adopter phase (for example, CG22, LA0). Similar concerns about delays in the production of the toolkit were voiced in a Programme Executive meeting we observed before the official toolkit launch date of 15 May 2014.

The cost of producing the toolkit

A substantial minority of our interviewees and people we spoke with during our observations expressed views about the cost and utility of both the co-design process and its product, the toolkit. When speaking of cost, interviewees variously spoke of the cost of consultancy involvement, the opportunity costs of attending a large number of meetings, or both. In particular, there were questions about whether the co-design phase and toolkit

could have been done another way – facilitated by, for example, local clinicians rather than external consultants. As one physician working for a provider trust noted in April 2014 when asked what advice he would give the programme team going forward:

> *I think it should be clinician driven, clinician led, clinician and patient driven. Why do we need to pay, I don't know how much it cost, but why do we need to pay an expensive external agency to do what is basically motherhood and apple pie? What's the final outcome of that: doctors, nurses, social workers, etc, get in a room and have a cup of tea and talk about patients. Fantastic. Why did it take millions of pounds… to achieve that?* (HP8)

Clearly, such a view must be balanced against the reality that virtually all of the clinicians involved in the WSIC programme will have busy day jobs and might therefore lack the capacity – or perhaps the managerial skills – to execute a large programme of change such as the WSIC programme.

Another respondent involved in facilitating the WSIC programme similarly questioned whether the toolkit represented good value for money, noting that while it was 'clearly leading edge thinking… how much difference it's made on the ground I'm not sure, and whether you could have used that £3.5 million or whatever it cost in a different way' (FA3). We consider this topic further in chapter 6.

Chapter summary

The WSIC programme has been developed in an evolutionary manner, building on experience and expertise gained through various prior initiatives aimed at enabling better integrated care for local people. It has maintained an inclusive, learning style comprising formative evaluation, incorporation of lessons learnt from the prior ICPs, but also international experience, as well as seeking external support from consultants and other expert advice.

The programme is very large in scale and scope, and its complex management and governance arrangements reflect this. It has taken a systematic and timetabled approach by which integrated care would become 'business as usual', based on shared vision, a ten-step implementation plan and a programme office that has provided highly structured operational and developmental support at the North West London and borough levels. The focus on appropriate governance is likewise mirrored by a strong emphasis on the inclusion of professional and lay groups.

Lay involvement has been a striking aspect of this inclusive approach, with significant time, attention, resource and support being provided to this part of the programme. While the co-design element of the programme has comprised primary, community and hospital services, NHS and local government, and some frontline staff, lay involvement became the principal defining feature of co-design and helped promote a focus on integration as personalised, coordinated care, among a number of other positive effects. These have been highly valued by those working within and alongside the WSIC programme. How far such involvement has enabled the wider engagement of communities beyond the lay partners themselves is yet to be seen.

Indeed, the overall inclusive approach to programme design and planning of local pilot projects has been much appreciated, but there are some concerns about an overall centralised approach to facilitating this involvement, resulting in some lack of sharing across workstreams and local early adopter projects. A further concern was the lesser involvement of the third sector and frontline care providers (including GPs) in some of the planning and design work.

The evaluation found evidence of both appreciation for the role of management consultants and the programme team alongside scepticism about the value that had been derived from such costly investment. In the current financial climate, it is likely the programme will be asked to account more explicitly for the cost-effectiveness of its current and past spending.

The WSIC programme has incorporated substantial elements of co-design and collaboration (especially between CCGs in the latter respect). It has been working towards a generalised but clearly articulated set of outcomes rather than targets. By the end of our evaluation, however, it was becoming increasingly urgent to have agreed measures in place at the local level and the programme as a whole in order to provide assurance about the achievement of the programme's quality improvement and cost-effectiveness aims. Subsequent chapters of this report are concerned with how far the transition from design to delivery has been secured and the lessons that are emerging from that process.
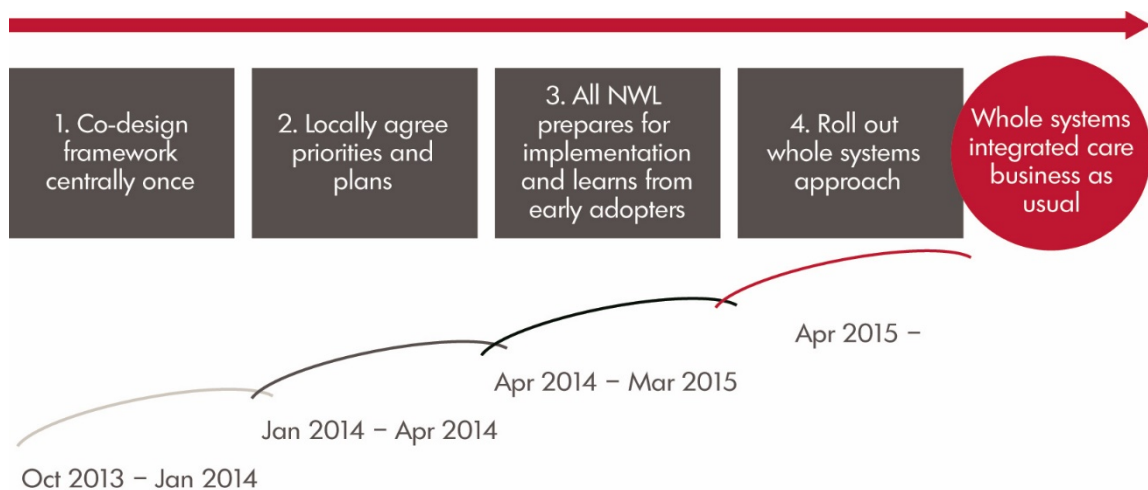
4.   The early adopter schemes

This chapter examines the second phase of the WSIC programme, which entailed the development of small-scale local pilots of integrated care known as early adopters. We outline the role of early adopters within the wider WSIC programme, the way in which they were identified and developed, and their resulting models of care. We also set out our assessment of the progress they had made by the time our formal data collection finished at the end of April 2015.

The role of early adopters within the wider integrated care programme

A central feature of the WSIC programme was a set of early adopter pilots intended to test out features of the WSIC vision so that lessons learnt could be incorporated into wider implementation plans of the programme across North West London (WSIC Programme Management Office, 2013a). The design of the early adopters was underpinned by a principle that it was necessary to 'test the model on a smaller scale, resource it in the right way, learn from that and then scale up' (FA2).

As shown in Figure 7, an early WSIC timetable, from December 2013, allowed one year for early adopters to pilot their new models of care with shadow budgets: April 2014 to March 2015, beginning about a quarter of a year later than specified in the pioneer bid. Slower than expected progress during the first half of 2014, however, meant that the pilot year was subsequently shifted to run from April 2015 to March 2016.

Figure 7: WSIC programme timetable from December 2013

Source: WSIC programme, North West London Integration Board presentation, 12 December 2013

The theory of change behind the early adopters was based on two assumptions. First that the early adopters would be able to take advantage of their small scale to move 'further and faster' and therefore be used as proof of concept (WSIC Programme Management Office, 2013a). As one interviewee articulated:

> *It's important that we can demonstrate, at a fairly small level, that there are tangible benefits…*
> *we can use that as a way of actually getting buy-in.* (PT4)

Second, that financial risk could be minimised by allowing local commissioners, managers and practitioners to test out complex issues on a small scale and, at least initially, in shadow form (for example, PT24, CG15). These issues included how to divide the population into groups of people with similar health and social care needs, and to link this to capitated budgets allocated jointly by health and local authority commissioners to networks of health, social care and third sector providers (for example, PT23, LP3). A number of interviewees noted that the programme had recognised that such innovations carried inherent risks and that it was necessary to 'enable people to fail a bit, to do that learning [because] there isn't actually a blueprint to getting this right' (HP11).

Developing the early adopters

Applications and selection

The nine early adopters resulted from a roughly six-month process that began in December 2013, when the WSIC programme team put out an invitation for expressions of interest for 'local areas… to trial features of a fully integrated system from 2014/15' (WSIC programme team, 2013). The invitation was left intentionally broad and framed as a 'journey being undertaken together, in a spirit of co-design and collaboration' – a further example of the emphasis on inclusivity which had already emerged during the co-design phase as a distinctive feature of the WSIC programme's approach to change.

Early adopters were advised that their submissions did not require 'detailed planning or onerous application forms – we would simply like to start the process of thinking through your idea'. At the same time, the invitation included a submission template, which encouraged cross-sector collaboration and provided a high-level framework for fitting local plans within the overall WSIC programme's vision.

In the end, 25 expressions of interest were received by the 7 January 2014 deadline (Table 1). One member of the programme team described the large number of applications as a general show of enthusiasm and 'big win' for the WSIC programme (PT1).

Perhaps the most interesting aspect of the application process, however, was how it took the idea of inclusivity so far as to ignore the commissioner–provider split. Indeed, the call for expressions of interest in December 2013 specified that these could 'come from any combination of provider groups and/or commissioners in the first instance' (WSIC Programme Management Office, 2013b). As one member of the WSIC leadership told us:

> *We completely disregarded the commissioner–provider split in doing it, and that's caused some angst from some of the local authorities and from some of the CCGs, saying, 'You're running completely roughshod over all our commissioning responsibilities'. And I'm glad we did because, if we hadn't, we would have massively constrained what people came up with.* (CG17)

Table 1 provides an overview of the different types of projects that were submitted for consideration in January 2014. It provides an interesting comparison to the final nine early adopters (Table 2 on page 49), highlighting the diversity of projects originally put forward, and the relative uniformity of those finally approved.

Table 1: Applications to be early adopters, showing target populations and final nine early adopters

Applications	Final early adopters
Brent • The top 2–3% high-risk adults and elderly people with ≥1 long-term conditions, ~6,000 people	**Brent**
Central London / Westminster • Elderly • Homeless • All adults with ≥1 long-term conditions • Mental health **Central London / Westminster** • Serious and enduring mental illnesses • All adults with ≥1 long-term conditions • Rapid access	**Central London / Westminster**
Ealing • Elderly with ≥1 long-term conditions; accelerated care for the top 2% at risk	**Ealing**
Harrow • Adults and elderly with 2 long-term conditions	**Harrow**
Hillingdon • Elderly and frail (initially)	**Hillingdon**

Hounslow
• Adults (<75) with ≥1 long-term conditions
• Elderly (≥75) with ≥1 long-term conditions
• Priority long-term conditions are:
  ○ chronic obstructive pulmonary disease
  ○ diabetes
• List size of 64,698
Hounslow
• Mostly healthy elderly
• Elderly (≥75) with ≥1 long-term conditions
• Elderly (≥75) with advanced stage organic disorders
• Total number 3,000 from list size of 54,759
Hounslow
• Mostly healthy elderly (≥75)
• Adults with ≥1 long-term conditions
• Elderly (≥75) with ≥1 long-term conditions
• Adults and elderly with advanced stage organic disorders
• List size of 46,501
Hounslow
• Elderly people with ≥1 long-term conditions
• Mostly healthy elderly people
• Adults and elderly with advanced stage organic disorders
• Total number 4,380 from list size of 57,175
Hounslow
• People with dementia
	Hounslow

Hammersmith and Fulham • Adults (<75) with ≥1 long-term conditions • Frail elderly (≥75) • HIV	**Hammersmith and Fulham**
Hammersmith and Fulham • Adults with ≥1 long-term conditions • Elderly with ≥1 long-term conditions • Over ≥75 with cancer • Over ≥75 with serious and enduring mental illnesses • Over ≥75 advanced stage or organic disorders	
Hammersmith and Fulham • Provision of a virtual ward for all patients in Hammersmith and Fulham	
Central London / Westminster • All adults with ≥1 long-term conditions	
Tri-boroughs • All service users who need support maintaining independence	
Hounslow • Adults with serious and enduring mental illness • Total number 499 from list size of 57,175	**Mental Health**
Pan-North West London • All serious and enduring mental illnesses	
West London and Kensington and Chelsea • Elderly people with ≥1 long-term conditions, and mostly healthy elderly people from a list size of 201,476	**West London**
Tri-borough • All adults admitted to Imperial College Healthcare NHS Trust and/or Chelsea and Westminster NHS Foundation Trust	
Inner North West London CCGs • Children, segmented into six segments with 4,000 assigned to each GP hub	
Hounslow and Hammersmith and Fulham • Cancer referrals to Imperial College Healthcare NHS Trust	
Pan-North West London • All cancer	
Pan-North West London • All service users (submitted by London Ambulance Service)	
Pan-North West London • All adults suffering from chronic obstructive pulmonary disease in North West London	

Source: WSIC Programme Management Office, 2014d.

In early 2014, it was generally felt among the WSIC leadership that there was capacity to support between eight and 12 early adopters.[17] This, however, presented the programme team in particular with a difficult choice: how best to select roughly this number of applicants whilst continuing the delicate balancing act from the co-design phase between inclusivity and local ownership, on the one hand, and standardisation and consistency, on the other. One member of the programme team summed this up when we asked how the final set of early adopters had been chosen:

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17 From notes of observation of the Programme Executive meeting on 7 May 2014.

I think we've needed to balance between ensuring local ownership… that this is the result of local, collective decision… but also… to remain faithful to the North West London vision and the work that's been done over the last six months. (PT4)

Ultimately a two-pronged approach was taken to address this conundrum, avoiding an explicit selection procedure altogether: informal networking among the local bidders was facilitated by senior members of the programme team over the ensuing months, encouraging them to collaborate with one another (WSIC Programme Management Office, 2014h); and a 'strategic alignment workshop' was held in early February 2014 to much the same end. It was made clear during this workshop that it was a 'matchmaking' event meant to bring some of the expressions of interest together. As one member of the WSIC leadership noted, 'we sort of broadly said you've got to get from 25 to something more like ten – without saying the number ten' (CG17).

Over the next four months, the 25 groups that had applied for early adopter status brought their proposals together and modified them; conducted further work on their own proposals; or withdrew entirely from consideration as part of what one senior WSIC facilitator described during a meeting we observed as a 'somewhat natural process'.

By early March 2014, a total of four applications had been resubmitted and signed off by the Programme Executive group, and resource for them released. These were: Brent, Hillingdon, Ealing and Hounslow (WSIC Programme Management Office, 2014c; 2014d). Over the next two months, a further six revised applications were submitted, from:

- Central London/Westminster
- Hammersmith and Fulham
- Harrow
- West London
- Chelsea and Westminster NHS Foundation Trust with the GP network in Hammersmith and Fulham called Network 2
- an application focusing on mental health services in several boroughs.

In summary, the early adopter application process was based on an approach that encouraged different local groups to get ideas out on the table quickly without commissioners and providers having to negotiate around each other. Subsequently, the local groups were encouraged to identify where they had overlapping and even mutually reinforcing but potentially duplicating bids, and to recognise that it was better to combine these rather than compete with each other – a win-win situation rather than a zero-sum game. In effect, competition was used to get ideas for projects, followed by guided collaboration to obtain approval for implementation.

Shifting the focus to the local models of care

After March 2014, detailed work shifted from the pan-North West London level to the local level. The emerging early adopters were given until late May 2014 to draw up outline business plans, to be presented to an external panel of sector experts for review in June

2014. They were to be supported in drawing up these plans by interim project managers who were funded for each early adopter through resource released from the North West London Collaboration of CCGs (see page 51). In some cases, however, not all of the project managers were in place early enough to fulfil this role. Five project managers were in place by mid-March 2014, and the remaining five by June 2014.

Between early April and mid-May 2014, a series of local working sessions also fed into the development of the outline business plans. These represented a substantial time commitment for the WSIC programme team, which organised and ran these together with those early adopter project managers who were already in place. Four were planned for each of the ten emerging early adopters and at least 24 had been held and an additional seven booked by 17 July 2014. The main focus of these local sessions was to develop the respective early adopter's model of care (WSIC Programme Management Office, 2015b). The six sessions we observed ranged in size from 25 to 50 attendees and varied considerably in terms of the diversity of organisations represented. The impetus to focus first on this aspect of design came from an email sent to the emerging early adopters shortly after the 'matchmaking', which noted that:

> *Following resubmission of EOIs [expressions of interest], the most important next step will be to co-create the new model of care in detail and to consider the related implications by mid-April…* (WSIC Programme Management Office, 2014i)

This approach had been discussed in an earlier Programme Executive meeting, where it was felt that other challenges, such as agreeing and implementing capitated budgets, would 'fall into place' once the early adopters had designed their models of care (WSIC Programme Management Office, 2014j).

Our overall reflections on the meetings we attended were that there was always a strong sense of commitment and expertise in the room. However, local professionals and lay partners were given relatively little time to really work on practical issues about what they wanted in terms of a model of care particular to their own locality. It seemed to us that the facilitators of these sessions had to cover so much ground in two to three hours that the process could easily feel too hurried, leaving some participants with the perception that their challenges or questions had not been adequately addressed. Some attendees told us during our observations that the solutions presented to them – for example the importance placed by facilitators on putting the GP at the centre of coordinating care; the WSIC approach to segmenting the population; or the use of capitated budgets – seemed pre-determined.

Of course, in essence these solutions *were* pre-determined as they represented the outcomes of the co-design phase, if not the pillars of the WSIC approach itself. However, concerns around the idea of local ownership that we picked up at each of the local working sessions we observed, and also heard in some interviews (for example, LA14, HP8, LP2, LP3, FA2), suggest that a co-design phase involving a relatively small number of local stakeholders at the pan-North West London level did not always succeed in producing a sufficient breadth and depth of ownership at the local level of implementation.

The external review panel in June 2014

By late May 2014, the ten early adopters had submitted their outline business cases to the programme team and begun preparations for the external review panel scheduled for 11/12 June, which comprised national and international experts in integration. The idea to bring in this type of outside expertise was to provide challenge and support to the early adopters and originated with the programme leaders and lay partners. It represents another instance of how they pursued a formative approach to the WSIC programme and its development. Our review of Programme Executive minutes from early 2014 suggests that there were voices from the beginning for and against using the event as a 'hard checkpoint', i.e., as part of the decision-making process around which applications to take forward (WSIC Programme Management Office, 2014k). In the end, the voices against using the panel event in this way prevailed, and it assumed a more supportive and inclusive role, with implications for the governance of the programme and monitoring of the early adopters' progress, which is discussed in chapter 5.

The more supportive role of the panel was set out as follows:

- to strengthen local early adopter plans

- to evaluate the WSIC programme team's plans for the next phase

- to increase external understanding of the programme.

(WSIC Programme Management Office, 2014c)

Members of the evaluation team attended both days of the panel event, and our observations suggest that those presenting their business case to the panel took the event seriously and were committed to putting the work forward well. In addition to our conversations with the participants, this was evidenced by their demeanour and the large amount of preparation they had clearly put into their presentations and outline business plans (which ranged from 36 to 106 pages in length). Conversations with some participants on both days also suggested that they may not have been made aware of the 'softer' role of the panel and therefore thought that future funding and support depended upon their presentation on the day (and the preparatory work prior to that).

Many of our early adopter interviewees who had been involved in the panel event reported that the advice given to them was challenging and useful, and that being able to point to external scrutiny was helpful when reporting back to their organisations (for example, LA0, HP11, CG1). One interviewee suggested, however, that for some of the early adopters, the preparation undertaken in advance of the panel event was more useful than the event itself (PT20). In addition to advice given by the panel on the day, the early adopters received individual, detailed written feedback and a panel member talked this through with them at a later date.

Importantly, our observations and review of programme documents suggest that preparing an outline business case for the panel event brought all of the early adopters to something of a common starting point and allowed for a greater degree of consistency and shared learning in their development than had previously been the case.

Lastly, the programme team used the panel event to encourage a coming together of the two quite different early adopters in Hammersmith and Fulham: the eponymous early adopter in that borough and the project led by Chelsea and Westminster NHS Foundation Trust alongside the Network 2 GP network. Both early adopters were asked to combine and make a single presentation in the same session. For some time after the event, however, both early adopters continued to exist side by side.

The final nine early adopters

The key features of these nine early adopters are summarised in Table 2, and can be compared with the wider range of proposals for early adopters set out in Table 1 (page 44).

Table 2: Key features of the nine early adopters				
Early adopter	Population group(s)	Size of population group(s)	Model of care	Piloting new model of care by end of April 2015*
Brent	≥65 with one or more long-term conditions	~11,000	Multidisciplinary teams, self-management, care plan	
Central London/ Westminster	<75 with long-term conditions ≥75 with long-term conditions ≥75 mostly healthy	59,938 (4,582 + 44,828 + 10,527)	Multidisciplinary teams, self-management, new care coordinator role, better GP access	
Hammersmith and Fulham	≥65 with long-term conditions ≥65 mostly healthy	Awaiting latest information	Virtual Ward (CIS), multidisciplinary teams, self-management, care plan	
Ealing	≥75 with long-term conditions	11,978	Multidisciplinary teams, self-management, care coordinator, GP at heart of model	✓
Harrow	≥65 with long-term conditions	36,478	Virtual ward to pre-empt deteriorations or crises self-management. The above supported by enhanced primary care provision.	

Hillingdon	≥65 with long-term conditions such as chronic obstructive pulmonary disease, peripheral artery disease, diabetes, stroke, dementia, mobility issues or social isolation	11,358	GPs as hub, care coordinator, care plan, overall team for care at home	✓
Hounslow	<75 with long-term conditions ≥75 with long-term conditions Adults and elderly with organic brain disorders	58,391 (47,687 + 9,865 + 839)	Multidisciplinary teams, self-management, care coordinator and plan, GP at heart of model	
People with long-term mental health needs – 2 early adopters	West London CCG	3,400	Community Living Well – addressing bio-psycho-social needs of individuals building on community assets	
	Brentford & Isleworth locality (Hounslow)	580	Wellbeing Network – using wellbeing mapping to agree goals and support recovery	
West London	≥75 with long-term conditions ≥75 mostly healthy	11,000	Single provider model, two integrated GP hubs	

* Our collection of data finished at the end of April 2015. However, we sought updates on this table in June 2015, which revealed that some components of an additional three early adopters had begun to be implemented (Hounslow, West London and Harrow). For further details, see Table 5 on page 71.

Organisation and governance

The early adopters can be regarded as virtual organisations that brought together commissioners, providers and other local stakeholders. Each organisation within an early adopter retained its own responsibilities (statutory or otherwise), as well as its own accountability and funding arrangements. With the exception of the Hillingdon early adopter, each early adopter was accountable equally to its CCG and local authority, and was expected to involve all partners in signing off plans, as well as to keep its Health and Wellbeing Board up to date (WSIC Programme Management Office, 2014c).

The typical organisational structure for an early adopter was to have a steering committee which met monthly and comprised a chair, a senior responsible officer, a project manager and representatives from each of the provider and commissioner partners. The structures

feeding into the steering committee differed among early adopters but commonly included working groups and provider forums. The provider forums were laying the foundations for future 'accountable care partnerships' – that is, formal collaborations of health and social care providers who are to be paid a fixed sum for meeting the full care needs of a population or population group, and take collective responsibility for meeting outcome targets for this group that are agreed in advance with commissioners.

Funding

The early adopters received the majority of their funding through the pooled 2.5 per cent service transformation budgets of the eight North West London CCGs (see chapter 2 for more detail). During the evaluation period, there were two tranches of funding received by each early adopter, with the exception of Chelsea and Westminster[18]:

- £50,000 in spring 2014 to fund an interim project manager

- £250,000 in autumn 2014 to support the development of early adopter business plans.

We understand that, at the time of writing in June 2015, plans were being developed by the WSIC Programme Executive and the Collaboration Board to release a further £750,000 of pooled CCG funds to each early adopter during 2015 once final business plans had been submitted and approved by their respective CCG's finance committees. In the areas where early adopter plans overlapped with those created for the Better Care Fund, additional funding was received from these combined local authority and CCG budgets. In both scenarios, the early adopters were required to keep their Health and Wellbeing Boards up to date on their development.

The continuing role of the programme team

A range of activities at the pan-North West London level supported the development of the early adopters after the panel event. The first of these was a set of working groups held between July and November 2014 to discuss pan-North West London developmental issues and deliver enabling infrastructure and support. During this time, a total of 19 meetings were held with almost 100 different individuals, some of whom sat on more than one working group (WSIC Integrated Care Toolbox, 2014, p. 22–25). Their outputs were used to form the WSIC Integrated Care Toolbox, published in December 2014. Its aim was to provide a set of handbooks for early adopters that would go into more technical detail than the toolkit, focusing in particular on the 'elements of the Accountable Care Partnership (ACP) that only need to be developed once but could be used by all early adopters to launch and operate an ACP' (WSIC Integrated Care Toolbox, 2014, p. 3).

The handbooks cover topics such as:

- Model of care and outcomes. Including information and examples of population needs and outcomes; self-care, interventions and processes; team structures; and operational planning; as well as a guide to operating the model of care as an ACP.

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18 All financial details have been obtained through personal communication with the WSIC programme team.

- Finance, analytics and information. Including a set of four 'dashboards' that could be used by the programme team and the local steering committees to monitor processes and outcomes of the early adopter work.

- Governance and contracting. Including sample contracts and illustrative governance arrangements covering joint commissioning; integration; and the creation of ACPs.

The optional nature of these handbooks was emphasised throughout. In a meeting of early adopter project managers, the materials in the toolbox were described as 'living documents', open to adaptation and continuing development by individual early adopters.

After the toolbox was produced, the programme team provided a range of ad hoc support to the early adopters at the pan-North West London level, whether in the form of targeted engagement through IT leads, or through working groups on outcomes and metrics. One offering in this category of support was referred to as the 'Change Academy', which was still being designed at the time our data collection finished at the end of April 2015. This was intended to include a range of activities for senior managers and clinicians, such as a 12-month leadership skills development course, masterclasses on specific topics (for example, service improvement or behavioural change), and support on how to access and use the materials in the toolkit and toolbox.

Parallel to this support at the pan-North West London level, the programme team worked closely with individual early adopters at the local level, attending steering committee meetings and supporting the development of local activities. This time commitment comprised a significant part of the role of the assistant directors in the programme team at the time.

In addition, fortnightly meetings of early adopter project managers took place in the programme office and were facilitated by the programme team. These meetings were used by the programme office to receive updates on progress made by the early adopters and, importantly, to communicate any developments happening at the programme level. In one meeting for example, the programme team provided an update on the training courses being developed for early adopters, shared feedback on an international study trip that had taken place, and provided an introduction the toolbox followed by a Q&A with the project managers. The meetings were also used as opportunities for the project managers to answer one another's questions and to share learning.

The early adopters described the programme team as being very supportive, particularly in relation to the materials produced (for example, the toolkit and toolbox) and in helping them think about and plan to address difficult issues. As noted in chapter 3, a large majority of the steering committee members who responded to our survey felt that the WSIC programme had clear leadership, as well as effective management and governance structures. Our interviewees also felt that the central team had been helpful in:

- sharing learning across the early adopters

- thinking through new ways of working

- providing support on how to set up new provider networks and associated governance issues

- setting up performance monitoring structures
- providing organisational development
- offering advice on how to engage with stakeholders
- provision of technical expertise (for example, PT20, CG11, CG20, CG4).

More recently, in late 2014 and early 2015, there were concerns that the programme team was overstretched and not able to provide the level of support needed at the local level, in part as a result of the diversity of support needed (TS2, HP13).

Provider involvement in the design of the early adopters

In general, patterns of provider involvement in the WSIC programme appear to have remained consistent after the pioneer bid was submitted in June 2013. One clear exception, however, was the third sector. When we asked early adopter steering committee members to rate how involved different providers had been in the design of their early adopter project, nearly two thirds of them reported that third sector providers had been very or extremely involved, ahead of local authority providers of adult social care and community health trusts (Figure 8). This was in marked contrast to the relative lack of involvement of the third sector in the co-design phase – something which one member of the programme team attributed at the time not to a lack of enthusiasm on the part of the third sector, but rather to the team not having 'invited them to the table' at an earlier stage (PT5). A third sector provider involved at a later stage of the programme noted in an interview, however, how difficult it is for the NHS to deal with a large number of very small and diverse third sector providers and the fruitless search for a single, representative third provider voice (TS1). The stronger involvement of the third sector in the early adopter phase of the WSIC programme may be an indication that the local level is the more appropriate (or, rather, more natural) level of engagement for the two sectors, at least for more detailed work on developing and implementing a new model of care.

In line with what our interviewees told us about the involvement of acute providers in the co-design phase, fewer than half of the respondents to our early adopter steering committee survey felt that acute providers had been extremely or very involved in developing their early adopter projects.

When it came to GPs and GP networks and their involvement in the early adopters, the picture painted by our interviewees was more varied. We were told that there was a core group of highly committed GPs, usually those with commissioning roles, but a wider group of GPs at the frontline who felt a general sense of detachment (for example, LA25, CG0, FA2). These observations appear to be supported by our survey of early adopter steering committee members, fewer than half of whom felt that GPs had been extremely or very involved – a figure which fell to around 30 per cent when our respondents were asked about the involvement of wider primary care (see Figure 8). Similarly, in our survey of GP practices in North West London, 50 per cent of GPs who completed the survey said that they had not been that involved or not involved at all in the WSIC programme and/or its early adopter projects. More positively, three quarters of GP respondents said that they had heard about the programme, although the depth of this knowledge was not explored.

Figure 8: Steering committee member survey responses to 'how involved have these providers been in the design of your early adopter?'
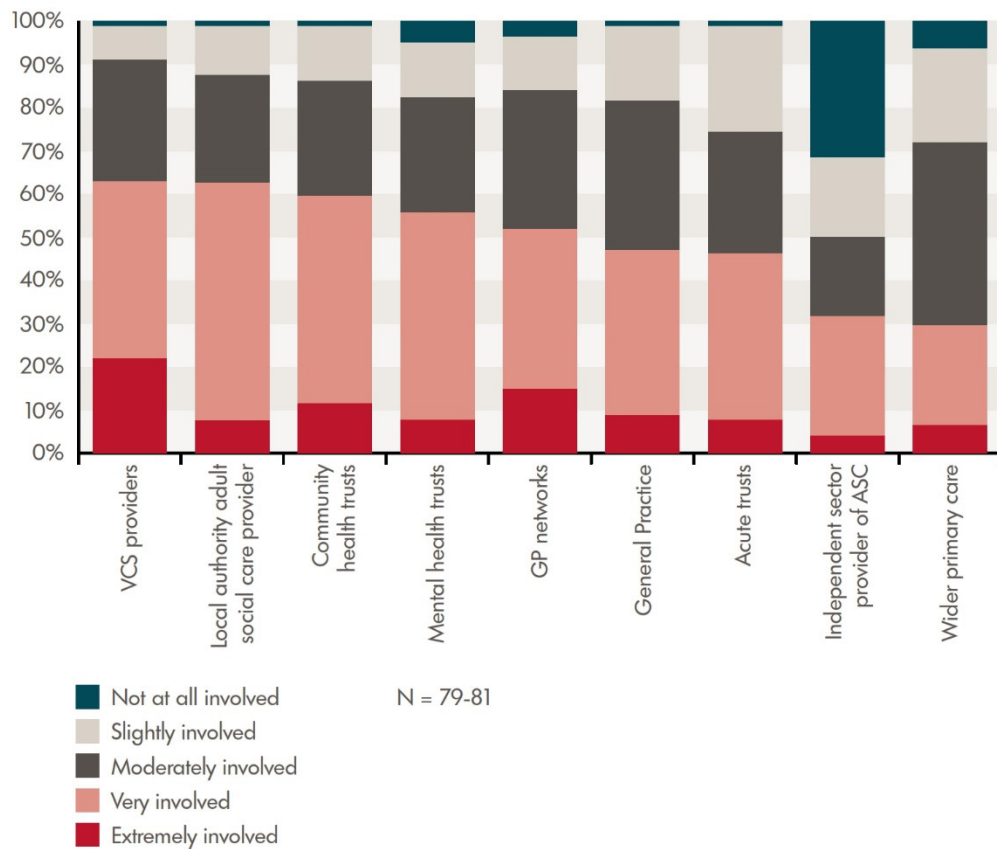
Source: Nuffield Trust/LSE survey of WSIC early adopter steering committee members (November 2014).
ASC, adult social care; VCS, voluntary and community services

According to our survey of GPs in North West London, workloads in general practice and support for GPs to work in innovative ways were seen as significant challenges to being able to achieve integrated care (99 and 90 per cent, respectively, agreed or strongly agreed). Another barrier identified in our survey challenges one of the fundamental principles of the WSIC programme, namely that GPs should be at the centre of coordinating care. While two thirds of GPs agreed with the statement that 'generally speaking, GPs should be "at the centre of coordinating patient care"', their reactions were mixed when asked what this meant in practice. Table 3 gives a sample of the responses.

Frontline staff were another group reported by steering committee members as not having been very involved in the development of the early adopters, continuing a theme that was apparent in the co-design phase. Some early adopters tried to rectify this by holding workshops and meetings with the wider workforce to discuss the emerging new models of care. By comparison, the lay partners, third sector representatives, and patients and carers were all seen by our survey respondents as being extremely or very involved in the design of their early adopter, although there was a suggestion that the level of influence and involvement of lay partners seen in the co-design phase had not been adequately replicated at the local level (CG20).

| Table 3: Free text responses to how GPs should be 'at the centre of coordinating patient care' was understood by GPs	
Positive interpretations	Negative interpretations
'GP should be aware of all the agencies involved and the GP should be able to communicate with them in a seamless manner and not having to fill in forms and go to different sites like e.g. coordinating my care.'	'Increased workload without proper resourcing, taking away time from patient care, service commissioning divided by CCG and borough, still lots of work in silos, lots of overlap'
'GP practices as part of a coordinating federation'	'I understand this as "when in doubt or can't be bothered to do anything for the patient, refer everything to the GP"!!!'
'GP is "co-ordinator" not necessarily provider. Not necessarily our job to arrange all items but should be central to knowing what is being provided to patient.'	'Doing the admin work of pulling all the teams together which, I think is admin and not GP. There needs to be a lead clinician though. Should be named but doesn't have to be a GP.'
'Organising social care, multidisciplinary teams as well as medical needs.'	'GPs may then end up carrying most of the responsibility for coordinating care which does not help with the increasing work load especially with complex patients'
'GP to signpost patient to the relevant services'	'We would take on more work'

Source: Nuffield Trust/LSE survey of GP practices in North West London (March–May 2015).

Our survey of steering committee members also asked about the involvement of commissioners in the development of the early adopters. In total, 87 per cent of our respondents felt that their CCG had been extremely or very involved (see Figure 9). However, the figure was considerably lower for other commissioners: 58 per cent for local authority providers of adult social care, 30 per cent for local authority public health, and 15 per cent for NHS England (London).

Our interviewees concurred with this view, suggesting that they felt the leadership of the programme was driven more strongly by commissioners in the NHS than those in local authorities, despite the underlying ethos of equal partnership between health and social care in the WSIC programme. One respondent, for example, commented that local authorities probably felt some responsibility towards the WSIC Programme Board but not the programme team, who were viewed as part of the NHS (LA0). Another reported that the involvement of social care in their early adopter steering committee felt 'tokenistic' at times (LA24).

Figure 9: Steering committee member survey response to 'how involved have local commissioners been in the design of your early adopter project?'
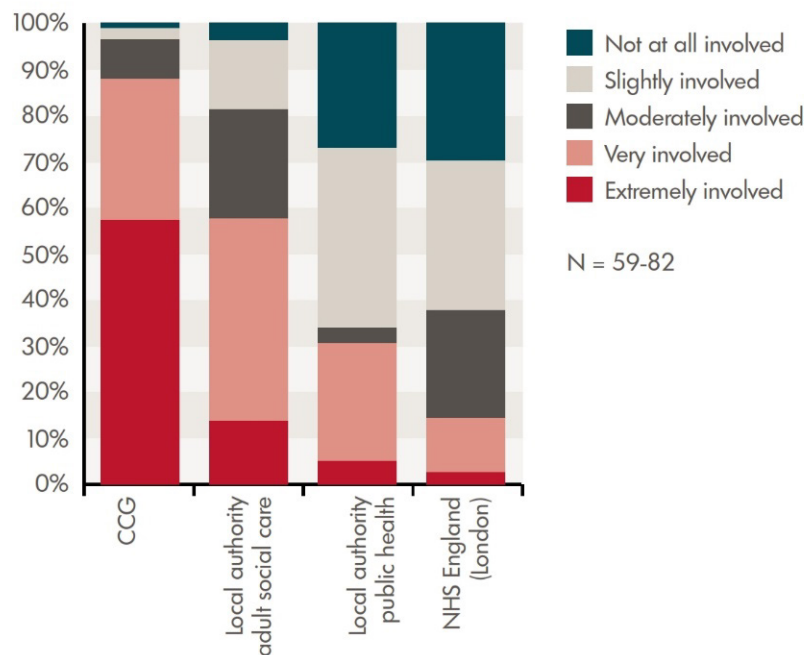
Source: Nuffield Trust/LSE survey of WSIC early adopter steering committee members (November 2014).

The early adopter models of care

Unrealistic timetables?

The design of the early adopters' models of care began in the working sessions organised and run by the programme team together with the early adopter project managers between April and mid-May 2014. This work continued after the June 2014 panel event in the individual steering committees, which in fact evolved from these working sessions insofar as their membership drew upon a core of local commissioner and provider leads who had been involved in the sessions.

For example, the steering committee of the Hillingdon early adopter took the outline business case submitted to the programme team in May and worked on the detail of its model of care well into December 2014. A member of the evaluation team observed several meetings of this committee, which covered items such as:

- the development of a pro-active screening tool to be used by GPs, social workers and others to identify people with unmet need

- outcomes and the metrics for the new model of care

- workforce implications, and descriptions of new professional roles and new ways of working

- workarounds to share care plans among providers when promised data-sharing solutions failed to materialise

- how best to roll out the new model of care (for example as a smaller pilot across a few GP practices, or across a wider patch)

- how to 'sell' the new model of care to frontline staff.

It is hard to imagine how the early adopter project in Hillingdon could have moved at a quicker pace considering the limited resources at its disposal and the fact that almost all of those involved had busy day jobs to attend to alongside their work on the WSIC programme. In this light, the timetable set out in Figure 7 on page 42, which envisaged the early adopter projects piloting their models of care from April 2014, seems overly optimistic. The implications of this are discussed in chapters 5 and 6.

A set of very similar models of care

A comparison of the original 25 expressions of interest and the nine early adopters' models of care reveals that the former were relatively diverse in their population focus, while the latter were broadly similar. Indeed, at the time of writing in June 2015, eight of the nine early adopters had chosen people over the age of 65 or 75 with one or more long-term conditions as one of their population groups. The early adopters' models of care also shared common features, such as the use of care planning, multidisciplinary teams and the GP as the first point of contact, which reflected the principles set out in the toolkit.

The general uniformity of the early adopters should not be seen as a problem in itself – the projects were, after all, set up as pilots to test different features of integrated care, not necessarily to cover a wide range of populations (at least not in the first instance). Moreover, alignment between the models of care might be seen as an advantage from the perspective of acute providers that have big footprints and were involved with multiple early adopters. What can be said, however, is that only two of the early adopters had chosen the mostly healthy elderly as one of their target groups, and none had focused on mostly healthy, non-elderly adults. Potential explanations for this and implications for the wider wellbeing agenda are discussed in chapter 5.

Our four case study early adopters

As a way of seeking to understand the implementation of the WSIC programme at a local borough level, we undertook a more in-depth exploration of four of the early adopters: Brent, Central London/Westminster, Ealing and Hillingdon. A description of how the case studies were selected can be found in the Appendix. Here we present the model of care developed by each of these four case study early adopters, the progress they had made by the end of April 2015, and our analysis of what facilitated or inhibited their work.

Brent early adopter[19]

The Brent early adopter is a collective of Brent CCG, Brent Council, London North West Healthcare NHS Trust (acute and community), Central and North West London NHS Foundation Trust, Imperial College London NHS Trust, Council for Voluntary Service

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19 This case study description was updated in July 2015 to incorporate details from the early adopter's full business plan, which was signed off by Brent CCG after our main data collection ended in late April 2015.

Brent and Healthwatch Brent. Like other early adopters in the WSIC programme, Brent's model starts with the focal point of GPs as central care coordinators, and building around that professionals working in a multidisciplinary way to enable patients to better self-care.

Box 2: Brent early adopter

The Brent early adopter is developing integrated, population-based care for people aged 65 and over with one or more long-term conditions. It builds on an existing programme in Brent that supports people aged 18 and over at risk of hospital admission. The early adopter has developed three care pathways:

- Enhanced mainstream care: helping those in the population group with lower levels of need, risk or instability manage their conditions effectively and remain healthy and well.
- Proactive care management: helping those in the population group with moderate to high levels of need, risk and instability to recover and to manage their conditions effectively so they remain healthy and well.
- Reactive care management: ensuring early identification and response by primary and community services to patients whose needs are escalating and support for people recovering from crisis or coming out of acute settings with raised levels of need, risk and instability.

In terms of implementing these pathways, it is anticipated that the model of care will include the following key features:

- Population group management and case finding – to identify people who could benefit from the Brent early adopter approach
- Multidisciplinary 'Core Team' directly linked to groups of GP practices and the GP networks
- Development of a shared care plan (including the patient's own goals and objectives)
- Development of shared care records
- Case management: supporting professionals in the core team to manage caseloads and deliver against care plans
- Care navigation: supporting patients and carers to set goals, plan their care, manage their care and review their progress
- Developing approaches to self-care and self-management
- New approaches to the management of escalation and crises in primary and community settings.

This is illustrated in a draft care pathway (see Figure 10) that was drawn up for the second cohort of service users identified – those in need of proactive care management.

As of July 2015, the partners in the Brent early adopter had signed off a full business case for a shadow year. They are aiming to work with approximately 10 GP practices across two early adopter GP networks. The shadow year will seek to obtain proof of concept for the new model of care and provider delivery framework. Provider partners are forming their shadow accountable care partnerships and preparing detailed delivery plans before undertaking an assurance process with commissioners and implementing from autumn/winter 2015.

Figure 10: Brent care pathway – proactive care management
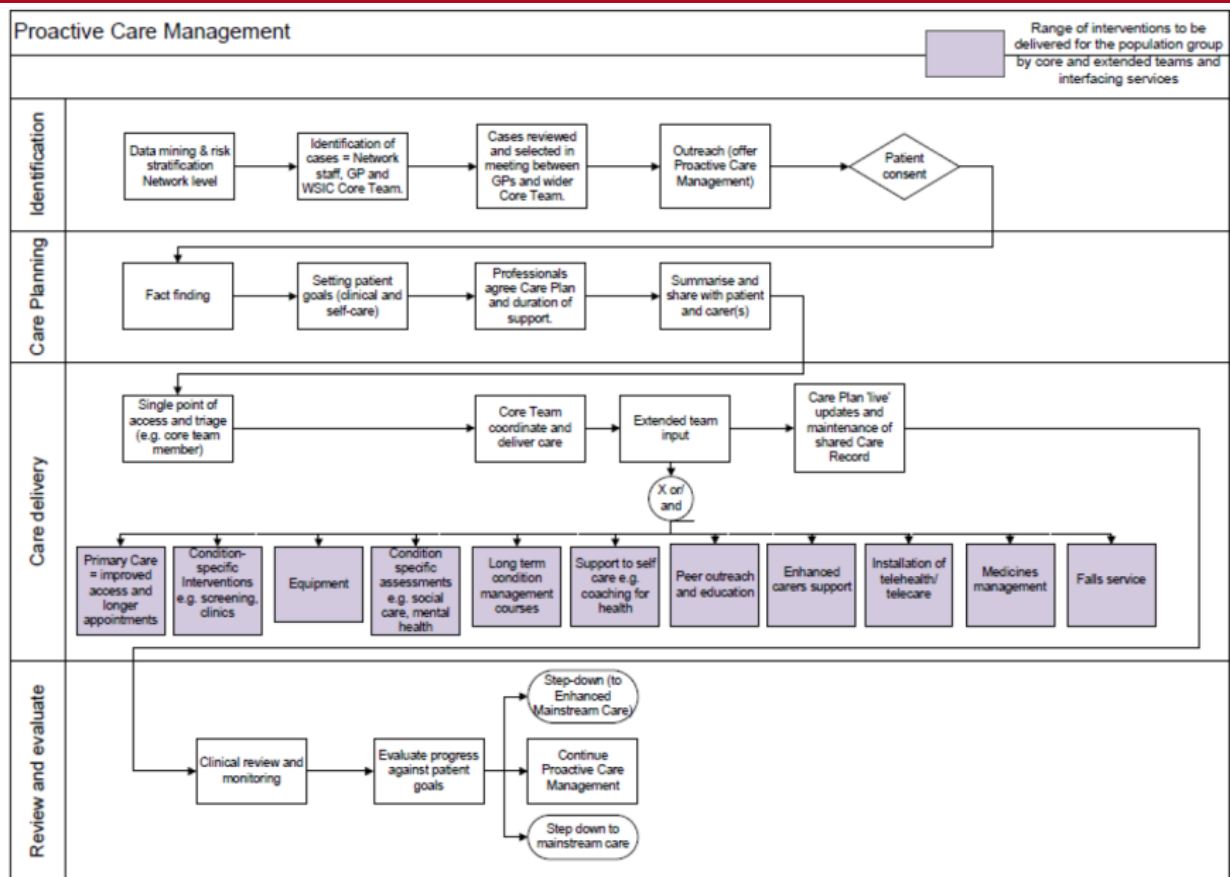
Source: WSIC Brent Early Adopter, 2015.

Brent early adopter had their full business case signed off by Brent CCG in July 2015. This document was the culmination of work that had been underway since the early adopter had their outline business plan agreed in June 2014. Activities during this year-long period included four day-long workshops, each with more than 40 people from a range of groups including service users, clinicians, managers and frontline staff from the health, mental health, social care and voluntary sectors. These workshops were designed by leaders on the early adopter steering committee who wanted to increase the involvement of frontline staff to the detail of the model of care, and took place between December 2014 and January 2015.

At the workshops, stakeholders helped develop care pathways, teams and roles, and identified success factors. There was also agreement that the intervention should be piloted on a small scale before being rolled out across the borough, as was consistent with the guidance coming from the programme team. This was summarised as focusing on 'depth over breadth'. The rationale was that a smaller-scale shadow year would help partners deliver and plan for the significant transformation and deeper integration required by the WSIC programme. This is reflected in the business case for the shadow year, which seeks proof of concept for the care delivery model and provider framework.

Since the workshops, Brent early adopter finalised their business case and had it signed off by Brent CCG in July 2015. As of that month, clinical leads and project managers for the two early adopter networks had been appointed and shadow ACP meetings had begun.

Provider mobilisation is due to take place until October 2015, followed by commissioner assurance and then implementation of the model in a shadow year, which will run from October 2015 until October 2016.

Based on modelled costings and activity, the total investment requested to deliver the shadow year and 'pump prime' the changes required was £1.22m. Approximately £350k of this funding has come from North West London transformation programme monies and the remaining £865k has been allocated by Brent CCG (see Figure 11 for a breakdown of how these costs have been allocated; WSIC Brent Early Adopter, 2015, p. 42). In addition to the £1.22m that is going to support the delivery of the shadow year, the Brent early adopter is also receiving £392k to support mobilisation of the programme (also funded by the North West London transformation programme).

Figure 11: Breakdown of the investment required by Brent early adopter for their shadow year (October 2015–October 2016)

			Investment - maximum	Shadow ACP - Harness	Shadow ACP - Kilburn	Commissioners (CCG)
Care Delivery	**Core Team**	Staff (backfill and new roles)	493,108	246,554	246,554	
		GPs and Practice Nursing (sessions per participating practice) District Nurse Social Worker CPN/PCDN Case Managers Care Navigators Pharmacy				
	Extended Team		79,050			79,050
		Budget for impact on wider teams and services (subject to evidence of resource requirement)				
	Management (care delivery)		285,318	142,659	142,659	
		2 x Clinical Lead - 4 sessions p/wk Operational management 1 x Analyst - (0.5 WTE per shadow ACP)				
	Total	All	857,476	389,213	389,213	79,050
Programme	**CCG Other Costs**		177,215			177,215
		WSIC 2 Patient Engagement & Comms , Evaluation & Review, Legal, Estate, Consumables and Transport				
	ACP Other Costs		140,000	70,000	70,000	
		OD, Volunteer support, Innovation				
	Contingency		50,000			50,000
	Total		367,215	70,000	70,000	227,215
Grand Total		All	1,224,691	459,213	459,213	306,265

Source: WSIC Brent Early Adopter (2015), Figure 14, p. 42.

As this is a shadow year to develop the model, complex risk/reward arrangements have not been applied. However, to replicate conditions under full implementation, the payment model seeks to hand over an envelope for the shadow year to be managed by the ACP providers According to the payment model proposed in the business case, any overspend by the providers will not be paid for by the CCG; however, use of an underspend of 20 per

cent or more (unless resulting from inefficiencies or non-delivery) can be negotiated with commissioners.

The success of the shadow year will be measured through a combination of North West London and local indicators aligned to WSIC outcomes that include patient-focused indicators. At the North West London level, a new survey will collect patient views on statements such as 'I can achieve my personal goals' and 'I have the opportunity to contribute and enjoy life'. Local indicators – some of which are listed below - will be applied with the aim of 'seeking to prove the model can deliver better care for the same or less cost'. The practices involved in the pilot will be measured against all practices in Brent. Data will be collected and reported locally by the shadow ACP.

- Number of non-elective emergency admissions to hospital

- Number of A&E attendances

- Rate of re-admission to hospital

- Rate of admission to long-term residential care

- Number of appointments in primary care (tracking reduction in 'frequent flyers' and 'do not attends')

- Reduced length of stay

- Improved discharge rate

- Increased number of days spent at home

(Source: WSIC Brent Early Adopter, 2015, p. 58)

A great deal of work is underway: draft memorandums of understanding for the shadow ACP are being developed; patients are being identified; teams and roles are being outlined; as are delivery plans. Locally, the early adopter has worked to secure the signing of information-sharing agreements between all 67 GP practices in Brent. At the pan-North West London level, the central team has secured the signing of information-sharing agreements with two of the three main trusts operating in Brent, as well as Brent local authority. Further work includes agreeing a memorandum of understanding between commissioners and the shadow ACP partners; launching the data warehouse locally; refining impact and outcome data and obtaining proof of concept; and participating in the Change Academy (see page 52).

As discussed later in this chapter, many of these tasks are often seen as the 'harder and organisational or systems' barriers to integrated care (Erens and others, 2015, p. 76), meaning that they are issues that are likely to be particularly difficult to overcome.

Central London/Westminster early adopter

The Central London/Westminster early adopter is focusing on the following population groups:
1.   18–74 year olds with one or more long-term conditions.
2.   75 year olds and over with one or more long-term conditions.
3.   Healthy adults over the age of 75 years.

To better serve these groups, the early adopter intends to build on the 'village model' introduced in Central London/Westminster in January 2014. The village model aligns participating providers around groups of GP practices, with each of the nine villages covering a cohort of about 20,000 patients. Village-working ensures that practices have face-to-face access to named representatives within provider organisations via multidisciplinary team (MDT) meetings. The providers include adult social care, pharmacy, a community health trust, GP practices, housing, mental health and the voluntary sector. One non-clinical care navigator per village provides support to the MDT, completing administrative tasks and making referrals into health and social care.

The early adopter aims to expand on this model by classifying all adults with long-term conditions according to the intensity of their support needs, as determined through risk stratification, GP assessment, the patient's own views and goals, and regular review. The aim is to enable MDTs to put greater emphasis on proactive, individualised care, give longer appointments to those who need them and involve appropriate third sector organisations in supporting service users' wellbeing.

The model also intends to give patients tools to better manage their own health and wellbeing. An enhanced care coordination function, with an increased number of care navigators operating to a wider remit, will serve as contact point for patients trying to find their way around the system.

It is anticipated that a shared IT record will avoid the need for patients to repeat their story multiple times, and allow providers of care and support to have access and contribute to a single care plan for each patient.

After presenting their outline business case to the external review panel in June 2014, the Central London/Westminster early adopter stakeholder group worked to refine its model of care, drawing up a principles of service document which details what patients can expect to receive at each of the defined levels. This was completed in December 2014. The process involved a range of meetings of the various provider and commissioner stakeholders (akin to the steering committee meetings in the other early adopters), as well as a programme of public involvement, including a large-scale simulation event around the new model of care. Lay partners were involved in most of these meetings and events, in some cases chairing or facilitating them.

Since then, the early adopter has focused on translating this specification into more detailed resource and staffing requirements, although progress in this area has been hampered by a lack of data on patient activity and a consequent inability to undertake the necessary financial modelling. A Provider Network Board (i.e., the early adopter's nascent ACP) was established in February 2015, and while no agreements about service change or contractual arrangements had been reached at the time our data collection ceased in late April 2015, conversations about these were taking place.

Rather than piloting the new model of care in its entirety immediately, the health commissioners started to lead the Central London/Westminster early adopter by taking a three-fold approach to change:

- To encourage providers to modify services within the framework of existing contracts, based on commissioner suggestions – for example, the providers were encouraged to change their referral processes to enable staff attending MDTs to take referrals directly from the meetings, thereby removing the need for paper referrals.

- To decommission individual services and replace them with new services that are more closely aligned with WSIC aims, such as the Patient Referral Service, whereby the current service was extended for six months while the role of the new WSIC care navigators was developed. This was done with a view to decommissioning the Patient Referral Service and including the secondary referral booking role into the wider remit of the care navigators.

- To ensure that any new contracts were aligned with WSIC goals and required outcomes, by introducing appropriate clauses around the need to work collaboratively and share data.

While the intent behind this approach has been to take small, gradual steps so as not to destabilise current service provision, individuals we spoke with as part of our meeting observations pointed out that there had been some frustration among GPs and other frontline staff in the borough about (possibly unavoidable) delays to implementation while the Provider Network was mobilised.

An important part of the context of the Central London/Westminster early adopter is the development alongside it of the Tri-borough Community Independence Service (CIS). This service encompasses rapid response, in-reach, rehabilitation and re-ablement delivered by health and social care teams working together in a coordinated way to support adults with complex health and/or social care needs (particularly vulnerable older people) in their own homes. The CIS is to be delivered by a network of providers, with Imperial College Healthcare NHS Trust as the lead provider. Several of our interviewees described the CIS as having built on the relationships, engagement work and operational support of the WSIC programme (HP5, CG22, PT8). As of late April 2015, the details of how the CIS and Central London/West London early adopter would interact and coordinate their services were being discussed by the various provider organisations, many of whom were part of both provider networks.

Since April it has been reported that the Provider Network has become a more autonomous group, working together under a memorandum of understanding. The patient groups covered by the early adopter have also changed – they have been expanded to include the over-65s (not just the over-75s, as previously stated).

The network has spent the last few months developing the process for determining the category of need for patients and working out the details of the enhanced care navigator roles. They are also in the process of identifying GP villages that can commit to being the first to test the new model of care.

The Provider Network was due to present its plans to Central London CCG's governing body in September 2015, with a view to starting the roll out of these elements of the model of care before the end of the year.

Ealing early adopter

The Ealing early adopter is focused on older people aged 75 and over with one or more long-term conditions. The model of care is summarised in Box 4.

Implementation of the Ealing early adopter started with a very small scale 'prototype' involving three GP practices in central Ealing, effectively serving as 'a pilot within a pilot'. It was in operation from February until May 2015, and there is to be a phased roll-out across the borough from June 2015 until March 2016. Its initial focus has been on 60 patients who were identified through risk stratification as frequent users of primary and secondary emergency care. Three care coordinators were appointed to gain experience of the role during the initial phase, and it was planned to recruit a further 11 care coordinators in early May. At the end of April, 42 people were receiving care coordination services, and initial evaluation data were being collected in the form of 'patient stories'.

Box 4: Ealing early adopter

Ealing was the first of the early adopter models of care to go live. It is focusing on people aged 75 and over, and with one or more long-term conditions, and aims to develop an integrated community and primary care service that can keep older people independent and healthy, able to stay at home for as long as possible, or be quickly discharged from hospital. Ealing's early adopter includes primary care, community health services, mental health, social care and the third sector. The early adopter's three main features are:

- Care coordinators who will manage the care of complex patients and ensure they are getting the services they need.

- Joint care teams for complex patients using a virtual ward model.

- Care navigators for less complex patients. Their role will be to provide advice and guidance.

In line with the Care Act 2014, the early adopter is also exploring how to improve social care support for those who are not eligible for state-funded support, for example by improving access to the third sector. They are also working to ensure that their third sector mental health services are compatible with local Improving Access to Psychological Therapies (IAPT) services. Community pharmacy is also an essential element of the Ealing model and plays a key part in the multidisciplinary joint care teams.

Figure 12 shows how the early adopter forms part of, and is integrated with, the wider system of care for its target population group.


It is important to add that the Ealing early adopter does not, at the time of writing, incorporate all aspects of the generic integrated care model developed during the co-design phase of the WSIC programme. In particular, it has not made a commitment to adopt either capitated budgets or form ACPs. Rather, we were told its philosophy has been to make more immediate progress by establishing additional services on the ground through the commissioning process rather than creating new provider structures.

Commissioners are reputed to have a history of working closely together in the borough and during the course of our evaluation the CCG moved its offices to the town hall. This

move was expected to promote more extensive and deeper working relationships across the staff of both organisations. At the same time, however, there continues to be an awareness that integration carries organisational risks, perhaps especially in the case of pooling commissioning resources and using capitation models of payment.

There has been some criticism of the Ealing early adopter's focus on general practice as promoting a model that is too narrowly medical. At the same time, however, the early adopter is intentionally designed to provide only one element of a wider system of integrated care (see Figure 12). The Better Care Fund has been used to strengthen another part of the local system through investment in more intensive home care services to cover different but connected parts of the care journey for those with complex needs.

Figure 12: Ealing integrated model of care
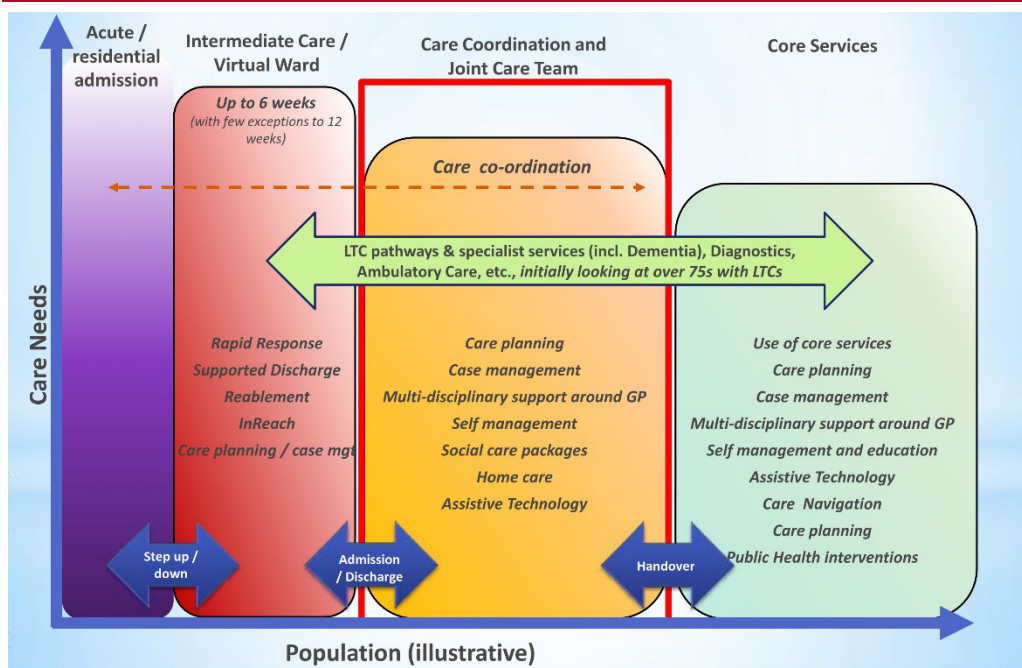
Ealing has also (and uniquely for this purpose) bid successfully for resources from a Department of Communities and Local Government (CLG) Transformation Challenge Fund to develop, for example, capacity in the third sector, together with self-care and social work input to the joint care teams. As a result, Ealing has been able to make a broader set of investments in proactive, preventive care for its target group. Our respondents told us that all three activities – the CLG fund, Better Care Fund and early adopter – are being managed in an integrated way by the joint management team of CCG and adult social care leaders. We have not studied this aspect of Ealing's work, but it clearly has the potential to deliver a coherent programme of mutually reinforcing activities.

A further significant aspect of the Ealing early adopter case study is that it identified the importance of cultural change across the workforce at an early stage in the WSIC programme[20]. This was primarily because the borough was one of a small number of

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20 Indeed, the national pioneer evaluation found it was one of the very few areas in which this priority was being addressed (Erens and others, 2015).

authorities engaged in the [Home Truths](#) project. The opportunity was taken to extend this work to the local NHS, and a bespoke development programme has been drawn up to support the early adopter. The programme is built on the recognition that system changes on their own will not be effective, and that relationships and behaviours need to be addressed at the same time.

Lastly, the Ealing early adopter, although behind the original timeline like all the others, is notable as the first to have begun operating, and now has a plan for roll-out across the borough during 2015/16. Whilst not, at this point, seeking to pilot the full range of mechanisms developed through the co-design process, it is being managed within a local whole systems context with the objective of integrating it into related programmes. Our data collection finished before the first 'patient stories' were available, and we can make no predictions about the outcomes it will achieve. However, it offers a promising context for comparison with other early adopters.

Hillingdon early adopter

The Hillingdon early adopter focuses on people aged 65 years or older who have one or more long-term conditions, notably dementia, mobility issues and social isolation. The project is part of an overall vision to establish an integrated health and social care system across Hillingdon, based largely on the principles of the WSIC programme and the pan-North West London reconfiguration of acute and community services in *Shaping a Healthier Future*. Other, wholly or in part, overlapping projects in the borough that are working towards these goals include the ongoing Outer North West London Integrated Care Pilot and the borough's Better Care Fund plan.

Box 5: Hillingdon early adopter

Population groups: People aged 65 and over, with one or more long-term conditions, for example chronic obstructive pulmonary disease, peripheral artery disease, diabetes, stroke, dementia, mobility issues or social isolation.

Model of care

The model of care will embed primary care-led anticipatory, multidisciplinary and coordinated care planning and review for appropriately targeted people, specifically those with long-term conditions, multiple frailty factors, and those at risk of crisis care or non-elective admission.

Patients requiring a higher level need of support will be serviced by a dedicated core care team. Lower levels of support will be provided by the GPs in networks and the third sector.

Key elements of the model be:
- Patient selection – proactive and opportunistic using holistic screening and assessment tools.
- Care coordination at lower and higher levels of need.
- Person-centred care planning.
- Single point of access to third sector services and new third sector support for people with low to moderate social care needs.
- Multidisciplinary team working.
- Remodelling of service functions to support delivery of the model.

Four organisations representing primary care, the third sector, acute and community services have come together and are forming a partnership that will be able to contract with the CCG for the delivery of integrated services.

The application for the Hillingdon early adopter was submitted on behalf of two GP networks in North Hillingdon: Metrohealth and Care4You. Other provider partners in the project are Central and North West London NHS Foundation Trust (community and mental health services), Hillingdon Hospitals NHS Foundation Trust (acute services) and a collaborative of third sector providers known as Hillingdon4All.

The early adopter's model of care is based on multidisciplinary and coordinated care planning and review, which will be led by GPs and will have a strong preventive focus on self-care and independence (see Figure 13 on page 69). The plan is for the model to have two tiers. In the lower tier, people identified as needing lower levels of support will continue to receive care from their GPs, who will have clear approaches to patient identification, care planning and multidisciplinary team working. Screening tools and risk stratification will be used to proactively identify people who would benefit from a care plan before their needs escalate and they become highly unstable.

The care planning approach is taken from the ongoing Outer North West London ICP, but involves an important change in funding: whereas GPs in the ICP were originally paid a flat fee for each care plan they produced, we were told that Hillingdon CCG was finalising plans in June 2015 to move to outcomes-based contracts, with an approximately 50/50 split between funding up front and a reward element for delivering agreed outcomes.

This is a further example of learning from past experience and evaluation. Indeed, one recommendation from the evaluation of the earlier Inner North West London ICP was that commissioners and GPs should prioritise the quality of care planning and embed mechanisms for holding multidisciplinary groups to account for the quality of care plans produced (Curry and others, 2013).

Lastly, this contracting is taking place on a network-by-network basis and, in the Metrohealth GP network, the ICP contract is actually being delivered as part of the WSIC programme – essentially covering the early adopter's lower tier of care.

In the higher tier, it is envisaged that people requiring a higher level of support will be referred by their GPs or other care providers to a dedicated core care team, which may be located in a facility tailored to this purpose (similar in some ways to the hubs to be implemented as part of West London early adopter).

This part of the model of care is likely to be focused more around the acute setting, proactively screening people around the time of hospital discharge and identifying those who are at high risk of re-admission or are having issues being discharged in a timely manner. As of June 2015, we were told that the details of the model of care, particularly in the higher tier, were still being worked out between the provider network group and Hillingdon CCG.

An unusual feature of the Hillingdon early adopter is its third sector 'Health and Wellbeing Gateway', a consortium of five third sector providers in the borough: Age UK Hillingdon, Hillingdon Carers, Disablement Association Hillingdon (DASH), Harlington Hospice and Hillingdon MIND. The idea behind the consortium is to provide a single point of access

for all health professionals in Hillingdon to the range of support and low-level preventive services available in the third sector.

The aim of the consortium, as expressed in a draft business case shared with the evaluation team, is to 'increase and maintain people's wellbeing, motivation and ability to self-manage their own health needs, thereby reducing future hospital admissions. It is intended that this approach will also promote more appropriate use of primary care, whilst addressing issues such as social isolation and low level depression' (Hillingdon4All, 2015). We were told that this project was given strong support from the programme team in terms of targeted engagement and advice, and funding was released through the early adopter steering committee to support the project lead in developing a business plan. The project lead is the head of Harlington Hospice and brings with him a background of senior-level work in the retail sector. While it is too early to judge how well the gateway will work in practice, good progress has been made so far and participants remain enthusiastic and committed to the project.

Implementation: a pilot within a pilot

Like all of the early adopters, the Hillingdon project is behind schedule. Nevertheless, it is the second one, after Ealing, to begin operating and seeing patients. Implementation of the lower tier of the model of care (see Box 5) began in April 2015 on a small scale in six practices in north Hillingdon. No additional funding was secured for double running costs, i.e., the practices were piloting the new service at their own expense. At the time of writing there were plans to test and review the new service until the end of June, and then roll it out across the remaining north Hillingdon practices between July and September 2015, with the third sector gateway and higher tier of the model of care to be developed in parallel. The goal is to have both tiers of the model in operation and to roll it out to other GP networks in April 2016.

We were told by two of our interviewees, and during a meeting observation, that the advice given by an external advisor from the US, Kecia Wherry, who has expertise in operationalising community-based, integrated models of care that were funded through grants and state insurance, had influenced their decision to start their early adopter on a smaller scale – particular in light of continued barriers to obtaining data on patient activity and sharing data between providers.

The four partner organisations in the early adopter – representing primary care, the third sector, acute and community services – are forming a partnership that will be able to contract with the CCG for the delivery of integrated services. The plan is to begin testing and reviewing a capitated budget model from late 2015.

In summary, the project appears to be more strongly focused than our other case studies on prevention and wellbeing, perhaps due in part to its strong and innovative third sector involvement. It is also of note that it and West London are the only early adopters with a lay partner as the chair of its steering committee. In Hillingdon, he is also the CCG governing body's patient and public engagement lead and, as we observed during our visits to the committee meetings, a strong advocate of a wellbeing focus. It is perhaps for these reasons that Hillingdon quickly embraced the programme team's recommendation to change its focus to those aged 65 and over from the original 75 and over age group.

Another point for reflection in this context is the relative lack of involvement of the local council, which is not an official partner in the early adopter but has collaborated with it by seeking to align work on the Better Care Fund plan with that of the early adopter.

Figure 13: Hillingdon model of care
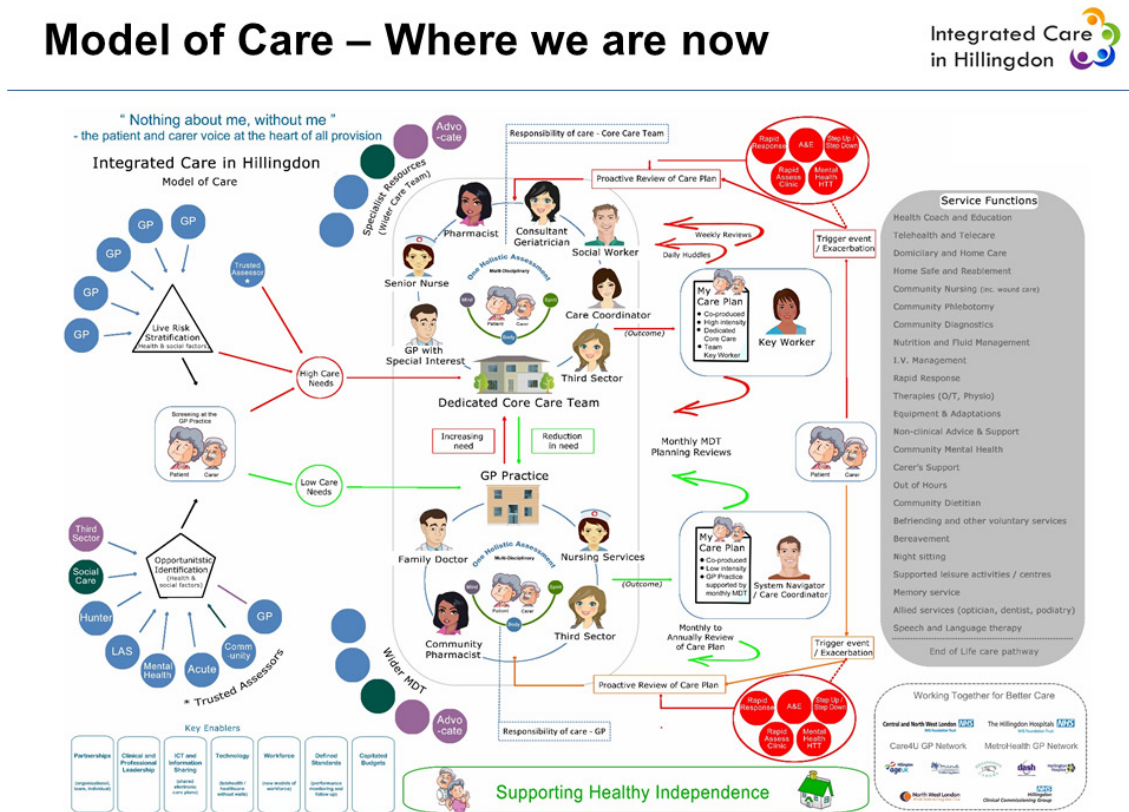
The early adopters' achievements to date

In our survey of early adopter steering committee members (November 2014), we asked respondents to comment on what achievements they felt had been made by their early adopter so far (that is, since spring 2014).

Cross-sector collaboration and the involvement of lay partners and patients were frequently mentioned as positive outcomes, in a very similar vein to what people reported as achievements from the wider North West London co-design process. Others commented on the enthusiasm and engagement that the programme had garnered for integrated care, the development of GP networks and the involvement of the third sector (see Box 6).

Box 6: Some of the achievements of early adopters, as identified by respondents to the steering committee survey in November 2014

What achievements are you particularly proud of so far?
- 'That all parties across the system are sitting at the table… good relationships are being developed across the respective partners'
- 'Can–do approach/pragmatic'
- 'Toolkit and inter-provider relationships'
- 'Level of engagement has been remarkable'
- 'Patient engagement – workshops where they out-number the staff!'
- 'A model of care that has innovation within it'
- 'The will to overcome the difficulties and succeed'
- 'Third sector [as] full partners'
- 'Early intervention at lower end of the risk pyramid model'

A lay partner who responded to our steering committee survey described their participation as a 'rewarding experience', and another reflected that 'for patients like myself to be so engaged as equals is most exciting and shows a real willingness to deliver patient-centred care in the community' (anonymous respondents to our steering committee survey, 2014). Relationships, particularly those between providers and commissioners, were important in determining the pace of progress made by individual early adopters. For example, interviewees made the following comments about the two early adopters who would be the first to have pilots in operation: 'Hillingdon from the beginning were very sorted and very there and very together' (PT5) and in Ealing: 'the council, CCG, community health providers, HealthWatch, the voluntary sector… have all been really involved from the beginning… nobody had to be won over' (LA0).

At the same time, respondents to our steering committee survey revealed significant gaps in their readiness for implementation by the revised date of April 2015. When we asked respondents whether they thought it likely that the ten steps on the journey to integrated care would be completed by that date, only four of the steps attracted a more than 50 per cent response rate (see Table 4).

Table 4: Likelihood that individual steps in the 'ten-step journey to integrated care' would be achieved by April 2015, as rated by early adopter steering committee members

	N	%
We will have agreed on the population to be included	74	69%
We will have agreed on the outcomes to be delivered	65	61%
We will have identified the budgets to be included	40	37%
We will have explored the pooling of commissioning budgets	35	33%
GP networks will have formed	65	61%
GP networks will have formed and acquired a formal legal status	45	42%
Provider networks will have formed	49	46%
Provider networks will have formed and acquired a formal legal status	12	11%
We will have designed a new model of care	62	58%
Provider networks will be delivering services within the new model of care	35	33%
Providers and commissioners will have agreed on how investment and risk are to be shared through capitated budgets	19	18%
Capitation allocation is being used by provider networks to cover services delivered within the new model of care	9	8%

Nonetheless, as our case study accounts reveal, two of the early adopters – Ealing and Hillingdon – were beginning to pilot some services at the time our data collection finished in late April 2015. In addition, we collected updates at the time of writing in June 2015 on the position of those early adopters which had not been case studies. These provided evidence that some components of three further early adopters had begun to be implemented from mid-April 2015 (see Table 5 for details). These developments were all relatively recent, and progress in all cases appeared to have been slow in the second half of 2014.

A number of our interviewees commented that time was running out for the early adopters to make decisions about their model of care, sign up local providers and make actual changes to services (e.g. HP1, LA24). A number, for example, suggested that the slipping of deadlines posed a risk to the continued engagement and collaboration of providers:

> *I'm sorry, people aren't going to turn up for another two years, it will have lost any impact.* (HP1)

The evaluation of the Inner North West London ICP also found that, while milestones and deadlines can be positive influences in generating momentum and focus, they can also threaten continuing commitment once they begin to be missed (Curry and others, 2013).

Table 5: Implementation progress updates, June 2015	
Hounslow early adopter	- Started a Community Recovery Service on 13 April 2015 which provides an integrated health and social care service for people who have had an acute illness, injury or change in health and social circumstance. At the moment, the service involves approximately 70 staff. - Pathfinder Project: two of the five Hounslow localities were pathfinders for social workers working as part of the multidisciplinary team in Hounslow. This has recently been rolled out to the five localities and an operating model has been developed. - Enhanced social work team for the acute trusts which is provided seven days a week.
West London early adopter	Since the beginning of June, five GP practices have been implementing a new model of care for a small numbers of patients – around three a week. The GPs are risk stratifying, care planning, running multidisciplinary teams and working across health, social care and the third sector. Further roll-out with 18 practices is planned for September 2015, and a further ten in October 2015.
Harrow early adopter	A virtual ward has been in operation since 28 April 2015. The virtual ward members have met seven times since it started, and have settled into a weekly meeting with care assessments and other necessary elements being delivered by the clinical ward members throughout the week, as needed.

Hammersmith and Fulham early adopter	• The early adopter is not yet implementing a new service, but is in the process of agreeing a programme of work for 2015/16 that partly builds on existing work (including Community Independence Service and Out of Hospital contracts) and partly looks to implement new pilots. For example, the early adopter is in the process of approving a social prescribing pilot in the borough, which is due to be implemented in two months' time and will involve two whole time equivalent coordinators in the first instance.

Barriers to implementation

Pan-North West London and national barriers

Despite signs that progress was beginning to pick up, it remains the case that the early adopters and wider WSIC programme are running significantly behind their original schedule (by some 15 months) for implementing new services and beginning to roll out integrated care as business as usual across North West London. It is also the case that the programme was built on the recognition that a number of significant barriers needed to be tackled in developing and implementing integrated care across the area. The major part of the co-design process was focused through the five working groups tackling tough questions in the problematic areas of: population and outcomes, GP networks, provider networks, commissioning and finance, and informatics. These issues were seen as the 'tough nuts' that it would be more effective to crack collectively, rather than eight times separately. Moreover, both the process and outputs of co-design would help to develop local implementation capacities and capabilities by building the relationships, knowledge and tools necessary to implement integrated care within CCGs and boroughs. When the initial co-design process was completed and the toolkit launched (in May 2014), the programme team continued to back the development of enabling infrastructures through the production of the toolbox, providing information and guidance on, for example, needs and outcomes; operating the model of care as an accountable care partnership; finance, analytics and information; and governance and contracting.

We have provided this summary to highlight the dependencies between the individual early adopters and the wider programme. If the purpose of the early adopters was to test out elements of the wider programme, the extent of local implementation was necessarily affected by the extent to which pan-North West London plans had been agreed upon.

This account does, however, beg the question of whether the WSIC programme has identified all the relevant barriers, as well as whether they have been sufficiently addressed through the production of tools and the development of local capacity. In practice, the evidence from our interviews and surveys suggests there is still some distance to go. The early energy and pace for the design and planning phase of the large-scale change in health care, followed by struggles and delays with implementation and roll out of new services, is something that is well documented in the research literature (Best and others, 2012; Bardsley and others, 2013). In addition, there is a well-evidenced tendency for integration

initiatives to focus on joint structures and processes, without necessarily producing better outcomes (Cameron and Lart, 2003; Wistow, 2011).

In addition, and while an advantage of such a large-scale programme is that it may be better equipped to address such matters more effectively than some of the much smaller-scale pioneers, barriers rooted in national structures and systems may still be insufficiently responsive to local initiatives to make the critical difference. It was that recognition which underpinned the national pioneer offer of combining local flexibilities with central government action to remove barriers where necessary, which has yet to be sufficiently fulfilled. The interim report from the evaluation of the pioneer programme (Erens and others, 2015) found that national barriers were generally limiting progress, including those associated with information sharing, funding levels, and the tension between sustaining acute sector provision while potentially reducing its provider role.

Our surveys of GPs and of early adopter steering group members begin to throw some further light on these questions, as does the national evaluation of the pioneers. For example, the survey of all general practices in North West London, conducted from March to May 2015, found very high levels of GPs agreeing or strongly agreeing that the implementation of integrated care in their area faced a number of key challenges (see Figure 14). Workloads in general practice were a particular challenge and, whatever their cause, they are clearly critical to a programme placing primary care at the centre of coordinating integrated care, even if GPs believed that new ways of working could reduce workload pressures.

Figure 14: 'To what extent do you agree or disagree that these are challenges for achieving integrated care in your area?'
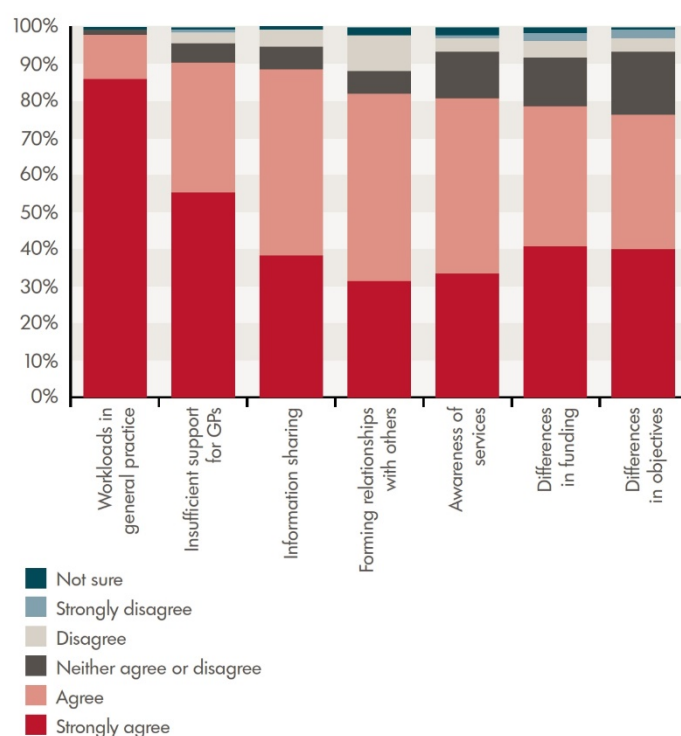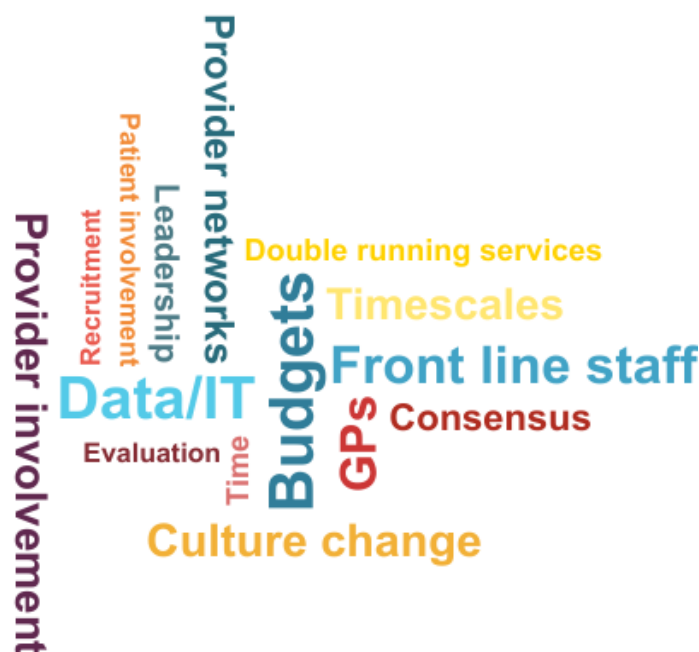

Source: Nuffield Trust/LSE survey of GP practices in North West London (March–May 2015).

In addition, most, if not to some extent all, of the challenges identified here are not wholly capable of resolution at either local or North West London level alone. This is not to say that local and sub-regional action cannot be taken to mitigate their impact, but workloads, conflicting objectives, different funding systems, information sharing and other factors all have national and local dimensions.

Our survey of early adopter steering committee members similarly found that respondents had encountered a number of barriers in moving towards the implementation of their local project. Figure 15 ranks in order of frequency those identified in free text responses. There is some overlap with the challenges identified by GPs, especially in relation to aspects of finance, informatics and GP engagement.

Figure 15: What are the main challenges to achieving integrated care in your area?'

The size of the word denotes how frequently it was mentioned by respondents, with the larger words being more frequently mentioned. Responses were grouped into themes.

Source: Nuffield Trust/LSE survey of WSIC early adopter steering committee members (November 2014).

Interviewees also commented on a number of barriers. Some identified aspects of their external environment as a source of slow progress, including the preparation of Better Care Fund plans and the demands of other national initiatives, caution about making waves in the run-up to the general election, and the implications for local relationships of hospital reconfiguration plans arising from *Shaping a Healthier Future* (for example, LA0, LA18, LA21, CG16). However, one respondent claimed that the WSIC programme had helped them progress their Better Care Funds plans, and our survey suggests that many felt the WSIC co-design processes had improved their relationships with other partners. The Better Care Fund was also found to be a facilitator in the interim report of the national pioneer evaluation (Erens and others, 2015).

North West London is not unique, therefore, in experiencing difficulties in moving from design to delivery. It is significant that some of the foundation stones for the WSIC model of care developed through the co-design phase included mechanisms such as accountable care partnerships, integrated commissioning, capitated budgets and information sharing. None of these are arrangements that are readily facilitated by mainstream governance frameworks in the NHS or local government. It is consequently unsurprising that each has provided a sticking point or source of delay in the various early adopter schemes. This being said, at the time our evaluation ended, the national agenda was showing signs of becoming more aligned with that of North West London (through, for example, the Vanguard[21] and devolution programmes), and it is to be hoped that the national offer to remove barriers will now begin to be fulfilled more effectively.

Local facilitators and barriers

Similarly, the history of joint working in North West London (as in the pioneers generally) was seen as an important facilitator. Indeed, in common with other pioneers (Erens and others, 2015), the WSIC programme was seen as a step on a journey that had been started through previous national or local initiatives, and which had prepared them to undertake the current development agenda. A history of collaboration and relationship-building is widely acknowledged as a facilitator of change in integrated care developments (Curry and Ham, 2012), and was mentioned by some North West London interviewees as evident in the ability of eight CCGs to form their commissioning collaborative and pool resources to implement the various transformation programmes.

However, the scale and complexity of the challenges facing a programme across an area such as North West London provide particular difficulties for providers and commissioners, including managing the risks posed, for example demands on time in a context of high workload pressures for management and frontline staff alike. In that respect, the inclusive approach to programme design was an added pressure, even though it was recognised to be of value. Moreover, as Smith and others (2013b, p. 21) found, a consequence of adopting an inclusive approach to programme development can be a tendency to spend more time on planning and design, and then to struggle when it comes to making firm decisions about commissioning new services and stopping the provision of others. Other related challenges included the difficulty of trying to bring together such a large number of providers, and establishing their various roles and responsibilities within a new model of care (e.g. CG0). In this context, it is particularly significant that the evaluation of the earlier national integrated care pilots concluded that 'the larger and more complex the intervention, the harder it seemed to implement the desired changes' (RAND Europe and Ernst & Young LLP, 2012, p. 75*).*

The interim evaluation of the national pioneers concluded that barriers to change can be described as the 'harder' features of integrated care programmes such as WSIC, covering issues related to organisational structures and systems (Erens and others, 2015). In contrast, enablers were 'soft' skills and more likely to include characteristics such as

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21 Established by NHS England in 2015, a number of 'vanguard' organisations and/or partnerships were set up in order to lead the development of new models of care, as outlined in NHS England's Five Year Forward View'.

'leadership, vision, trust, values and continuity of relationships' (Erens and others, 2015, p. 76; see also RAND Europe and Ernst & Young LLP, 2012; Curry and others, 2013). The same picture has been found in this study of integrated care in North West London.

Progress made by the early adopters

The original intention of the early adopters was to create small-scale pilots to go 'further and faster' in testing out various parts of the WSIC programme, especially capitated budgets and accountable care partnerships. This has been coupled with work at the pan-North West London level to develop frameworks and tools for these and other aspects of the infrastructure for integrated care, including contracting and information-sharing agreements. This division of purpose has remained unchanged throughout the course of the programme, with some early adopters planning to work on an even smaller scale to test out their pilot with a few practices before rolling out to a full GP network and then their whole borough.

The process by which the final set of early adopters was selected is an example of the 'push and pull' relationship between the central programme team and local early adopters, with the relationship being both collaborative and restrictive. The size of the WSIC programme and the number of partners has been a strength, but has also added complexity.

Since their formalisation in March 2014, following the submissions of expressions of interest and the release of funding to support their development, the early adopters have moved at different paces. Some of this was expected, and was indeed encouraged by the WSIC philosophy of allowing local innovation to solve local problems. However, it has also created problems; the most striking of which is that while some areas are beginning to pilot new models of care, others are a long way off without a clear idea of when they will be ready to pilot something.

It is not clear what will happen from a governance perspective if they are unable to actually put in place the plans they have made. The variation in progress made by early adopters has also meant that it has been difficult for the central team to provide the diverse and tailored support needed by each of the nine schemes. Unsurprisingly, progress has been faster in areas with strong, pre-existing relationships, and where some of the foundations of the WSIC programme – integrated services or GP networks – were already in place.

Well-known barriers to integrated care such as information sharing across sectors and differing funding arrangements, continue to stall progress in North West London. The reaction to these barriers by the early adopters has varied, with some piloting what might be considered scaled-back models of care that do not require these changes to funding and IT, while others are still working their way through the more process aspects of restructuring care across sectors.

For some involved in the WSIC programme, differences in approach by local schemes was appropriate and reflected different contexts and priorities across North West London. For others, there is a concern that having various groups implementing distinct projects could lead to further fragmentation of the system, particularly in the inner boroughs of North West London where acute providers work across local authority and CCG boundaries. This tension and others are discussed in chapter 5.

The WSIC programme has repeatedly described itself as being inclusive of diverse groups and interests, as did the Inner North West London ICP before it. It has, however, structured and organised itself in a way that has tried to ensure a degree of standardisation and consistency across early adopters, using the toolkit to present evidence that would influence and support decisions related to the selection of the population groups and delivery mechanisms. This has meant that the resulting pilot sites were initially similar in their focus, though we have shown that they are developing some differences of approach to implementation in, for example, Central London, Hillingdon and Ealing.

More generally, the development of smaller-scale 'pilots within pilots' is consistent with international advice given to the early adopters, including that following the visit to all early adopters in early 2015 by Hal Wolf , a former senior vice president and chief operating officer of Kaiser Permanente in the US. Indeed, he suggested following a 'natural pace of change', particularly with regard to signing up providers who were already under a great deal of pressure due to the external context (LA0). Similar advice was given by Kecia Wherry, an external advisor from the US who was seconded to the North West London programme for 12 months based on her expertise in operationalising community-based, integrated models of care which were funded in the US through grants and state insurance. Along these lines, when asked what advice they would give to others implementing a new integrated care model, a representative from one of our case study sites reflected 'just do it and keep it simple' without waiting for all the pieces to be in place (LA25). The same interviewee perhaps indicated, however, a degree of scepticism about the need for all elements of the wider North West London approach to integrated care:

> *Better information sharing, working in the spirit of partnership and making flexible use of resources is actually going to be much more important than a fantastic capitated budget thingy.* (LA25)

By contrast, other respondents viewed capitated budgets and the development of accountable care partnerships as a demonstration of their innovation capabilities and proof that the WSIC programme would do something genuinely different, using phrases such as 'the litmus test' of the WSIC programme to describe them (HP16, HP9, CG0). However, as we have already noted, we also encountered a view that 'time was running out' for the early adopters and the wider programme to prove they could adopt and put their plans into practice.

Other respondents commented that it was easy to get 'obsessed' with data and IT issues, and that that, in itself, could stall progress (LA24). Nonetheless, it is clear that the initial expectations of early adopter implementation had not been met in part because of barriers associated with information sharing. Moreover, in the absence to date of national action to address this barrier fully, it remains to be seen whether North West London can put in place its own solution. More generally, the respondents who were advocating what we might describe as 'getting on with job' might have been expressing frustration with the slow pace of progress in addressing the major infrastructure barriers, and/or a reluctance to adopt the more radical changes implied by such components of the WSIC model such as its informatics, accountable care partnerships and capitated budgets initiatives. Either way, the alignment of the early adopters with the core infrastructure mechanisms for supporting the delivery of integrated care in North West London remained incomplete at the end of March 2015 when our programme of data collection was planned to end.

Chapter summary

Early adopters are a critical and central feature of the WSIC programme, forming nine pilot sites within the wider integrated care endeavour in North West London. They enable the testing out of principles and practice as described in the WSIC Integrated Care Toolkit, and are an opportunity for local practitioners and lay partners to put in place the integrated care models and approaches developed in the early stages of the WSIC programme.

Significant resource has been invested in the WSIC programme, with some other investment being made in the early adopters, in particular support for project management and business planning. What is less clear is how far there has been practical support for testing new models of care; namely making changes to the services offered to local people by community nurses, social workers, home care assistants and others.

At the early adopter level, as with the wider co-design process of the WSIC programme, activity appears to have focused on planning and design work, with much more limited progress in the practical implementation of new services, and with contracts and funding flows changed to enable to this. As with wider evidence on integrated care (including the national integrated care pioneers), it is the 'soft' factors of relationships and partnership working that seem to have enabled initial change, and yet the 'hard' aspects such as IT and data governance, budgets and contracts have been seen as barriers to progress. This begs a question as to how health and social care change can be brought about in practice, and when relational work should be superseded by the transactional (Smith and others, 2013b).

The implementation of the early adopters was running 15 months behind the original schedule at the conclusion of our evaluation, with little in the way of actual changes to service delivery having been made. The toolkit and toolbox had been developed and published, many people engaged, and extensive consultation undertaken. When examined through the lens of the early adopters, the WSIC programme is at a critical point in its development; namely finding out if it can now move from design to implementation with local services being delivered in different ways.

5. The approach to change

Chapters 3 and 4 outlined the development and early implementation of the North West London WSIC programme. In this chapter we analyse how the programme has interpreted its vision and principles; review the approach to change it adopted; and conclude with an assessment of the critical stage at which the programme was poised by late April/early May 2015.

Vision and principles

The WSIC programme set out its ambitions in terms of better health and care outcomes for people in North West London, to be secured by supporting them to remain independent for as long as possible and lead full lives as active participants in their communities. Care out of hospital was, therefore, expected to become the first point of call. Programme leaders reported that this vision was derived from the views of patients and service users in earlier design workshops and surveys.

The vision was widely recognised by those we interviewed for this evaluation as being person-centred, transformational and ambitious. These characteristics were captured by a senior NHS provider interviewed for this study, who described the aim of the WSIC programme as being to 'defocus on the organisation and refocus on outcomes for people, a really scary thing' (HP16). A leading primary care clinician saw it in no less far-reaching terms as 'shaking down all the old and arcane buttresses we have and the different silos we work within, and working in a very new, refreshing patient-centred way' (HP8). One consequence of adopting an outcomes-oriented vision – which was widely recognised – was that integrated care and governance ought not to be seen as ends in themselves. As a senior local authority officer emphasised, 'integration is not the goal; the goal (i.e. vision) is the goal' (LA11).

In this respect, the vision for the WSIC programme was consistent with the national definition of integration as 'person-centred coordinated care', the means by which 'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me' (National Voices, 2013).

WSIC and local acute services reconfiguration

The terminology of 'whole systems' suggests that WSIC sought to offer a comprehensive approach to integrated care across North West London's health and care economies. In practice, however, the 'whole system' to which it referred was the system of out-of-hospital care, a system being developed to complement the *Shaping a Healthier Future* plan for acute hospital reconfiguration in North West London, which had been initiated earlier. The three underlying principles of this plan – localisation, centralisation and integration – combined elements of vertical and horizontal integration within the NHS and between the NHS and local authorities, respectively.

Respondents in this evaluation generally appreciated that the integration of primary and community services was the 'flip side' of hospital reconfiguration. Indeed, as noted in

chapter 3, the North West London pioneer application was explicit that its goal was to reduce unnecessary hospital admissions by strengthening community-based care systems so that out-of-hospital care 'routinely became the first port of call'. This emphasis was arguably reinforced by the subsequent national conditions for the Better Care Fund, which likewise sought a focus on reducing avoidable hospital admissions.

The sequencing of the acute and out-of-hospital plans had a number of consequences for the implementation of the WSIC programme. NHS commissioners, in particular, argued that the prior agreement of hospital reconfiguration plans was a positive influence:

> *The potential threat posed to acute provider business by integration of out-of-hospital care is less of a factor here because… all the (acute) chief executives and medical directors have signed up to that end point… So our discussions are more on how long will it take to reach the end point and how to reach it.* (PT7)

The same respondent thought that the task of the WSIC programme would have been 'impossible' under any other circumstances. Another similarly emphasised that prior agreement of the acute plan provided an essential foundation for the WSIC programme. North West London had 'already got past some of the really, really difficult conversations about the impact on acutes, which has made (WSIC) successful' (PT5).

That this phasing had been more fortuitous than planned was seen to be a learning point for other areas. A CCG respondent observed:

> *It's become increasingly obvious that implementing the hospital reconfiguration programme does actually mean, 'Sort out your out-of-hospital programme as well.' And we always said that integration was a key part of the CCGs' out-of-hospital strategies. And I think we've now alighted on the fact that, actually, whole systems integration is really the big story in out-of-hospital care.* (CG17)

Another similarly emphasised the wider importance of this learning point:

> *Other areas in the country are going to struggle to deliver out-of-hospital care if they're not essentially closing or reconfiguring some hospitals, and the people that haven't worked that out can't understand why they're not going anywhere with their integrated care stuff.* (PT5)

The view from local government

Although NHS respondents identified benefits – even though often unplanned and unanticipated – from this sequencing of acute and out-of-hospital plans, the story in local government was different. Acute reconfiguration plans attracted strong political opposition and were significant issues in both the 2014 local and 2015 general elections. At the time of writing in June 2015, they remained the subject of an external committee of enquiry commissioned by a number of the local authorities in North West London and chaired by Michael Mansfield QC. This opposition has led to some highly charged meetings between council members and NHS managers, both in private and public. They also resulted in council officers having to be cautious that work on integrated care was not seen by members of the public as supporting the A&E closures required as part of implementing *Shaping a Healthier Future.*

Despite these difficulties, some senior local authority officers also saw them as providing evidence of the strength of relationships between the NHS and councils:

> *I've had this conversation with the leader (and) [they are] very clear about differentiating between the two [closing A&Es and the WSIC programme]. So we will make our political statements and raise our political issues on those, and we will get on with the other things somewhere else because you can't just break the whole relationship over one disagreement, so I think it's quite a mature relationship in that sense.* (LA17)

Other senior officers recognised the need to separate different agendas, with one arguing that:

> *There's a bit of me that says if Health and Wellbeing Boards had been around for five years rather than one year, we may not have been as vociferously opposed because we would have been part of understanding the dilemma. We don't want people going into hospital, that can't be a goal, but because we weren't part of the thinking, it's easier to oppose.* (LA22)

How 'whole' is the WSIC programme?

This research revealed some confusion within North West London about how the WSIC programme aligned with the wider strategic health and social care plans in North West London. This confusion was recognised by the central WSIC team for whom the programme was 'not something on the side but main business' (LA14), whilst they realised that for others, such as local government and acute care providers, the WSIC programme could, at times, seem less connected with other important programmes.

Part of the problem was understood to be a lack of clarity about how the plethora of central government initiatives joined up at the North West London level and the associated risk of change fatigue (CG3). As a result, there was a perception in some quarters of 'people get[ting] incredibly confused'(LP3) and 'not all talking the same language' (LA8). A respondent from the programme team underlined the simple message that all the national initiatives were 'part of a general movement into a different model of health and care' (CG7). Another expressed frustration at the inability to see that 'actually, really what it's about is joined up personal care for people' (PT6).

The need to cut through the apparent confusion and adopt a similarly direct message was echoed at the borough level.[22] One area was 'keen to drop the various branding and just have 'integrated care in (borough name)' (LP3). Another argued that more effective communication was essential to facilitate implementation and mitigate risks to its success:

> *I don't think it's so much a case of resistance; I think it's a case of people not knowing about it… I think communications is a really key thing. I think we need to be really clear in the vision that we're articulating and why we are doing this. Because, I guess, misinterpreting those messages can mean that people perceive it as a threat.* (PT4)

Hence, respondents identified a need to 'produce a single narrative for change' (LA6) and to 'keep describing the vision' (CG8). Others saw a need to go further than clearer or

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22 The term 'borough level' is used to describe the local level at which CCGs and councils operate, and does not refer exclusively to an individual London borough council, its members, officers or services.

repeated messaging, including the advocacy of 'one coherent whole transformation programme or we will end up with a lot of plates on the floor' (CG3).

It seems to be true that, initially, to use the words of one observer, there was 'no slide that explains the relationship between all the initiatives' (LA6), at least in slide packs we saw early in the evaluation.[23] In practice, however, the relationships are now commonly depicted as a set of intersecting circles representing four workstreams underpinning the collective vision:

1. Service reconfiguration under *Shaping a Healthier Future*

2. WSIC programme

3. Primary Care Transformation

4. Patient empowerment as, for example, in the Central London CCG Contracting Intentions for 2015/16 (Central London CCG, 2015).

Similarly, the North West London Financial Strategy for 2014/15 depicts four key transformation programmes supported by four crosscutting workstreams (workforce, information strategy, estates and communications). How far the relationships across programmes are fully understood, or perceived complexity reflects a lack of collective ownership of the vision, remain valid questions. We therefore need to consider whether some of the reservations reported above reflect something more substantial than unclear communication of a well-developed strategy.

There seem to be at least two sources of uncertainty in these comments: first, what was in or out of scope of the WSIC programme itself, compared with the other transformation programmes. In retrospect, adopting the 'whole systems' terminology for only one of several related programmes can be seen as a self-imposed source of confusion, and all the more so when combined with the simultaneous need for stakeholders to understand and rapidly navigate a series of different national initiatives in this and related fields. At the same time, however, the lack of clarity reported by stakeholders and the frustration of some in the programme team that the essence of 'joined-up personal care' was becoming obscured may point to a deeper lack of understanding or ownership of what integrated care meant for their organisations and ways of working.

In the latter context, it may be argued that the WSIC programme had specifically established a co-design process to help build such understandings and ownership. The toolkit (in Section 3: 'How will it feel?') does contain a strong narrative summarising 'how things will be different if you are a person who uses services or a carer'. There are similar narratives written from the perspective of commissioners and different categories of provider. Yet the slow take off of the early adopters (see chapter 4) suggests that much remained to be accomplished, both to complete the design of core elements of the programme (for example, capitated budgets, information sharing, provider alliances) and to embed in working practices the nature of the changes necessary to make a difference for patients and service users.

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23 For example, Nuffield Trust Challenge Session, Background Material, 16 January 2014 (WSIC Programme Management Office, 2013c).

This leads to the further reflection that co-design should perhaps be seen as a necessary but insufficient condition for major organisational and cultural change. In North West London it was inclusive but not especially extensive when compared with the size and diversity of the workforce, or intensive when compared with the depth and embedded strength of the professional and community interests affected. In particular, the engagement of frontline staff appeared to receive little attention at the co-design stage. Participants in the process were seen as potential ambassadors or 'evangelists' (CG10) for the WSIC programme and, from our observations, many certainly appeared to have that capacity. Some members of the programme team commented that participants in the co-design process had not been effective in cascading information and understanding of the WSIC programme back to local level. However, their impact might have been greater if they had been prepared for, and more actively encouraged to adopt, such a role.

The Change Academy, which is now coming on stream (mid-2015), is designed to address issues associated with the depth and extent of preparedness for transformational change. Ideally it will serve a vital role in embedding the commitment to different organisational configurations and working practices that the WSIC programme has identified to the implementation of its vision. It is possible that an earlier starting point for such work might have helped accelerate the process of bringing the early adopters into operation.

The vision, principles and process of the WSIC programme

The WSIC programme involved a detailed plan for the programme of change, comprising:

- a vision
- three principles of change
- a ten-step implementation process
- a timetable by which integrated care would become 'business as usual'.

In addition, the programme adopted an inclusive learning style, of which the commissioning of a strong formative component to this evaluation is one example. Other examples of putting this approach into practice include: the commissioning of external support; the early adopter model; recruiting a panel of experts to meet the early adopter teams and provide feedback on their outline business plans; and inputs (including a secondment) from experts with relevant implementation expertise. While the design and implementation of new developments can sometimes be constrained by the 'not invented here' syndrome, the WSIC programme has been significantly more open to learning from external experience and advice.

The vision of integrated care developed in North West London is consistent with the national emphasis on integration as a means towards personalised outcomes for individuals and their carers:

> *To improve the quality of care for individuals, carers and families, and to empower and support people*
> *to maintain independence and to lead full lives as active participants in their communities.*
> (WSIC Integrated Care Toolkit, 2014)

It is expressed in terms that are arguably more consistent with a social than a medical model of health, given its emphasis on empowerment, independent living, community participation and support for family carers as well as individuals. This vision is accompanied by three key principles about empowerment of individual service users through home support, GPs as coordinators of care, and ensuring that systems enable integrated care.

Implementing a predominantly medical model of health?

Local authority respondents in particular felt that the implementation of the WSIC programme did not fully reflect the breadth of its vision. For example, the programme seemed to give more weight, in practice, to a medical model of care, with its emphasis on the central role of the GP in delivering care and support at home or in the community, rather than supporting independent living and active participation in community life as advocated in the vision statement. It is also notable that the pioneer application (NHS North West London, 2013a) contained a fuller version of the first principle that included a commitment to joint working to promote whole person wellbeing:

> *People and their carers and families will be empowered to exercise choice and control, to manage their own health and wellbeing and to receive the care they need in their own homes or in their local community. We will work together to promote the long-term, sustainable wellbeing of the whole person.*

That emphasis on health and wellbeing is not only consistent with the North West London vision, but also the national policy document proposing the establishment of pioneers (National Collaboration for Integrated Care and Support, 2013). The latter highlighted the importance of primary prevention and early intervention to promote health and wellbeing in order to respond to the needs of growing numbers of people with multiple comorbidities and also to address inequalities in health.

The North West London pioneer application adopted a similar approach and acknowledged that 'promoting the long-term, sustainable wellbeing of the whole person will require a preventative and personalised approach, taking into account the social determinants of health and wellbeing' (NHS North West London, 2013a, p. 12). In addition, it stressed the commitment of its members to work with a wider range of partners on issues such as housing, leisure, transport, education, employment and probation. Moreover, Health and Wellbeing Boards would lead whole systems work locally and, with public health sitting in local authorities, there would be new opportunities 'to collectively address the economic, cultural and environmental influences on people's health' (NHS North West London, 2013a, p. 8).

On paper, therefore, there appears to be a greater degree of consistency between the WSIC vision and principles as expressed in the pioneer application than in more recent documentation. Those who were conscious that some degree of disconnection had appeared between the focus of the pioneer application and its implementation tended to be primary care clinicians and local authority representatives. Their concerns revolved around the relative absence of priority for primary prevention and the social determinants of health.

A senior social care interviewee, for example, identified a mismatch between the WSIC vision, on the one hand, and the programme's focus of activity and the breadth of its partnerships, on the other:

> *The programme is really about redesigning the acute and community services offer, so we're a long way from social determinants of health.* (LA8)

A senior GP argued that shifting resources towards prevention and wellbeing was essential to sustainability in the NHS:

> *If we don't force the Better Care Fund to enable social services to work jointly with us for our elderly population and not duplicate, and get upstream with some of these problems, then it's all going to come tumbling down our [around] ears in 2015/16. It's in danger of tumbling down [around] our ears anyway in 2015/16 because I've got a local trust that can't afford to run itself and doesn't know how to get rid of some of its overhead costs.* (CG16)

This comment exposes a fundamental dilemma about the extent to which resources should be invested with the objective of sustaining current systems compared with investments to manage demand in the longer term. A local authority respondent suggested:

> *It's understandable, because clearly that's where the orthodox view is, that too much of the resources are being deployed, and it's a dilemma we're facing in all our services, so how do you fund the upstream preventative stuff without taking it away from those who are currently in benefit because they didn't have the upstream preventative stuff.* (LA3)

This focus on only parts of the care and support system is reflected in the content of the ten-step implementation process and the predominantly medical models of care at the heart of almost all the early adopters. As a local authority interviewee noted:

> *We have used the toolkit as a methodology for co-designing a particular model for part of what the whole systems approach is trying to achieve… Once you accept that the model is a medical model, then the toolkit and the whole (co-design) approach was very useful.* (LA7)

Early adopters' and GPs' interpretations of the WSIC vision

Among the nine early adopters, Hillingdon has the most a substantial focus on 'upstream' working. It considered that the WSIC programme was 'too clinically focused' and extended its target population to those with lower level needs in order to test out ways of working with that group. By contrast, leaders of the Hillingdon early adopter felt they could 'look for quick wins on the high level part of the model which we know how to make work' and did not need to establish proof of concept (CG15). As a result, Hillingdon changed the age group that its early adopter covered to those aged 65 and over 'because we recognised preventative, early proactive interventions work as a key component of the early adopter, with things like social isolation being a determinant of people's health' (LP3). In turn, this focus led to the third sector being recognised as a core provider and, uniquely, forming its own 'accountable care partnership'. Other early adopters focused primarily on meeting the needs of frail older people with multiple comorbidities in order to reduce the more immediate pressures of demand on bed-based services.

Data from a web-based survey of each GP practice in the eight North West London CCGs provide us with evidence that substantial proportions of the GPs who responded[24] had recognised the need for improved integration. Almost two thirds (65 per cent) agreed or strongly agreed that GPs should be at the 'centre of coordinating care patient', although as some of the additional free text comments indicated, this view did not necessarily mean that GPs should themselves take on the care coordination role, or that they approved of being allocated this central role.

A limited interpretation of 'inclusivity'

Inclusivity has been a central element in the WSIC programme's way of working. However, at both programme team and early adopter level it has understandably been inclusivity as interpreted through the lens of the principles that shaped the ten-step implementation process. With the important exception of lay partners, engagement was almost exclusively limited to NHS and a smaller number of third sector organisations and adult social care participants (who have not always found it easy to be fully engaged because of the various pressures facing local government). In addition, the lay partners' presence was less strong when the WSIC programme was initiated and the national integrated care pioneer bid written (see chapter 3).

Importantly, there is little evidence that the WSIC programme had engaged sufficiently with the wider range of stakeholders, especially in local government and the community, whose involvement was identified in the national call for pioneer applications as necessary to address the social and economic determinants of health. Housing and public health are two critical examples. In practice, therefore, the scope of engagement has tended to reflect the requirements of vertical integration within the NHS, as well as horizontal integration with social care where this has had a necessary role in supporting the medical models adopted locally.

This focus of the WSIC pioneer is reflected in the leadership of their programme, the membership of its programme team, and its role in supporting the acute reconfiguration programme. Moreover, a crude analysis of the contact details provided to us to carry out our survey of early adopter steering committee members suggests that NHS-related individuals predominated in these bodies (see Table 6).

Table 6: Estimates of the sector in which invitees to the steering committee survey worked		
	N	%
NHS	124	72%
Local authority	20	11%
Voluntary and community sector	15	9%
Unknown	15	9%
Total	**174**	

Note: It is likely that some respondents have multiple roles and may span sectors. It is also possible that those classified as 'unknown' may be lay partners.

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24 The survey had a 39 per cent response rate.

A pragmatic response to current pressures?

The focus of the WSIC programme on primary care and vertical integration within the NHS is not necessarily inappropriate and may reflect a deliberate assessment of where the greatest benefits are to be secured for service users in the current financial climate, at least in the short term. The issue for consideration is whether the NHS, which has provided most of the leadership and resource for the WSIC programme, has defaulted into a way of working that is unlikely to secure the transformative goals implied by the local and national pioneer visions. The predominance of NHS leaders within the programme's structures has been a major contributor to its focus on immediate health service concerns at the expense of prevention and wellbeing. This move away from the wider place-based approach contained in the WSIC programme's pioneer bid raises a question about how the WSIC programme has sought to balance responses to short- and medium-term health and social care pressures, against initiatives to address determinants of health and wellbeing that may have more limited pay back in the short term. At the same time, it can reasonably be argued that the national priority given to reducing avoidable admissions in 2015/16 and extending integration at 'scale and pace' by 2018 provides little space for taking a longer-term view. Moreover, financial, and consequentially capacity, constraints have seriously limited the ability of local authorities to engage fully in the programme.

Assessing the WSIC approach to change

We have examined the nature of what the WSIC programme is attempting to achieve and how its focus has appeared to shift since the pioneer bid. We now explore how the WSIC programme has sought to achieve its goals by considering its ways of working, and the structures and mechanisms through which it has operated.

A distinctive scope and scale

As noted in chapter 3, one of the most fundamental factors shaping the WSIC programme and its operating culture is its scale and complexity in terms of population, number of partners and size of the local economies involved. Another basic characteristic is the highly systematic programme management approach that has shaped and driven its design and delivery. It is also unusually well-resourced with programme staff, development budgets and consultancy support, especially compared with other pioneers. Many of these features derive from its origins in an environment with a history and culture of collaborative working in the NHS (including the pooling of commissioning resources and budgets), between individual local authorities and across different combinations of health and social care economies.

The influence of the prior ICPs in North West London

Not all aspects of the prior ICPs were considered to be positive. Some respondents with experience of the earlier Inner North West London ICP commented on its top-down nature, using terms such as 'mandated' and 'imposed' to describe both its content and implementation. This experience exercised a significant influence on thinking about the WSIC programme's approach to change and its operating model. One member of the programme team described how they spent time over the summer of 2013 'working out

what, in the programme, we don't like regarding governance' (PT24). A senior health provider we interviewed in spring 2014 pointed out that one of the lessons learnt from the ICP had been the realisation of 'the extent to which people kick against top-down anything. And there was some kicking against a sense that certain models of the ICP had been imposed' (HP4). The provider in question described how this had resulted in 'an attempt to be more inclusive' but added that 'it does still feel quite centrally driven at this stage' (HP4).

The importance of this lesson was acknowledged within the programme team. One of the team's members observed in autumn 2014 that:

> *The ICP had a very standardised way of doing things, and that almost gave people the idea that you kept always within that standardised way of doing things, and I can see now that that made some people feel that it was imposed rather than owned.* (PT7)

The tension between programme team support and local initiatives

This learning contributed to the embrace of co-design and piloting as the respective core features of the two phases of the WSIC implementation model on which this evaluation is based. The rationale for both included recognition of the need for inclusivity to promote local initiative and ownership, a feature of North West London described by one observer as 'going wider to go forward' (FA1), though some respondents were critical of the way inclusivity compromised the pace of change.

At the same time, however, this way of working reflected the emphasis on individual CCG sovereignty that formed an explicit feature of the agreement governing the North West London CCG Collaborative. Similarly, although three local authorities shared a single management team, and others operated through a looser alliance, the sovereignty of individual councils was considered paramount (as Hammersmith and Fulham's review of its membership of the Tri-borough arrangements demonstrated).

Programme team members suggested that they were well aware of these organisational and political constraints, and shaped their approach accordingly. One observed that:

> *So in essence they (the local areas) have to lead the work, and it has to be their work: it has to be owned by them – otherwise, it's not going to work really; it will just fall over as they get into the next phase. And there is a tension that we don't always get… right.* (PT4)

The latter view was widely shared outside the team, though not all interviewees were critical. For example, an acute provider emphasised in spring 2015:

> *I don't think I've seen a better organised piece of programme and project management. It's without doubt an exemplar inasmuch as there's been total clarity on the timescales, there's no ambiguity on the outputs… and the quality of the products that they're producing… is very high.* (HP5)

A CCG source similarly emphasised the focus it provided, stating that they 'suspect we never would have done anything in whole systems if we didn't have the driver (of the North West London programme) behind us or we would have but it would have been really slow' (HP10). However, another interviewee challenged the argument that the programme team insured against resources being wasted by eight localities constantly reinventing the wheel:

> *Change happens faster and more effectively when it is really locally owned… people almost have to invent their own wheels… I don't see any better quality or depth of debate in North West London.* (HP4)

A local authority manager complained that 'feeding the North West London beast' was a distraction from developing local initiatives and noted that 'when the centre (any centre) is ready, it switches on and wants everything to happen tomorrow' (LA8). A senior primary care clinician was concerned that WSIC ways of working were characterised by a 'potential [to] over focus on process, and we need to constantly challenge ourselves [about] what the goal is so we don't lose it… [and can] explain this is how it makes a difference to the patient in front of me' (CG16).

Locally many interested parties remained unconvinced that the best balance of resources and efforts was being secured. For example, there was some scepticism about the authenticity of the switch to a less prescriptive approach compared with the ICP. A primary care clinician argued 'the whole systems programme is still top-down but we're doing our best to make sure that nobody realises it…' (CG16). Yet the same respondent also emphasised that:

> *If you want to organise something as big as the ICPs or the whole systems, you have to start at the top because nobody at the bottom has got enough connections or clout to join it up. And the art of getting managers and clinicians working well for patients is going to be how much you drive from the top and when do you then let go...*

Others thought the current balance was still less than optimal. A CCG commissioner thought they 'would probably advocate a little bit more devolution' while, nonetheless, accepting the balance that had to be struck between 'making sure that the resources [were available for] supporting… local change, but at the same time having enough capacity and capability to also manage some of those wider issues that a single CCG can't solve by themselves'. Such issues included IT, information-sharing agreements and legal contracts for setting up provider organisations: 'these are things that can and should be shared' (CG14).

There are also issues that the WSIC programme and local leaders should be able to address. For example, the programme still appears to be struggling to find the optimum balance between a number of factors such as: collective leadership and local autonomy; integrated commissioning and integrated provision; NHS leadership and local authority engagement; and locally appropriate variation and acceptability, and programme-wide consistency and standardisation. Managing such tensions is integral to a programme such as this, and requires a form of management ('systems leadership') that has been likened to 'being comfortable with chaos' (Timmins, 2015). As the same source points out, NHS leaders have relatively little training or experience in managing systems as opposed to organisations. Yet doing so is a style of working that is becoming increasingly relevant as public sector managers recognise the complexity of addressing the needs of an ageing population or reducing health inequalities. The ability to work through hierarchies must be complemented by skills in working across organisations and through networks to achieve better outcomes for people and places in a cost-effective way.

The role of external consultants

A related feature of the Strategy and Transformation work that attracted a degree of attention among our respondents was the role of external consultants working within the team. McKinsey, in particular, was seen by some to have contributed to 'driving a top-down approach' (HP4) and perhaps imposing its own model onto North West London:

> *McKinsey, having got the brief, are very clear about what they think is the answer particularly around ACPs and capitated budgets, whereas others increasingly have doubts about that.* (LA19)

A number of interviewees questioned the cost of consultants compared with, for example, the level of direct financial support given to early adopters (up to the end of 2014/15). Others considered the quality of the co-design process and its outputs (the toolkit and toolbox) to be high. This view was supported by findings from our early adopter steering committee survey, which showed that three quarters of respondents felt the toolkit had been helpful to the design of their project. Some interviewees' responses suggested it had been used more as a source of reference than a practical guide, and some questioned its shelf life. Positive support for the team and its outputs came from the following source:

> *People in the team are really good and working really hard, but there aren't enough. Without team materials inputting to my work, I just couldn't keep on top of it. It's too big a piece of work for the workforce we have (and would be) … virtually impossible without the North West London team.* (CG19).

A concern about the recruitment of external consultants for programme management support was related to their inevitably transitory nature:

> *By definition, they come and go. You lose the continuity and the continuity of information and corporate knowledge; and culture can only be built with permanent staff at ground level. So it is better to use ground level staff, backfill [and] only bring in temporary staff if you have to.* (LP3)

This view reflected a broader assessment in late 2014 of the need to rebalance investment and support at North West London and early adopter levels, respectively, prompted both by concerns that if the balance between top-down and bottom-up influences had been appropriate at the outset, they had ceased to be so as the early adopters prepared to 'go live'.

Shifting the balance towards the early adopters

The required balance between central and local roles varied as implementation progressed. In particular, while there had been acceptance of the programme team as a means of creating collective purpose and momentum through the co-design phase, this was increasingly questioned as the WSIC programme progressed to the development of the early adopters.

A critical turning point appears to have been the visit of the expert panel in June 2014. As explored in chapter 3, the panel's role evolved from taking decisions about which early adopters would go forward, to providing supportive, external feedback as well as an internal deadline for the preparation of outline business cases. Even so, in some quarters, there was concern about how the process of review risked becoming excessive, for example:

> *The whole process felt heavily over engineered, there were endless preparations for the visit, we submitted endless papers and got some value but not much.* (LA19)

The expression of such views led to a discussion at the October 2014 Programme Executive, at which the programme team pointed out that it had no authority other than that given to it by the CCGs and boroughs. As a result, the meeting was said to have concluded that:

> *Rather than creating more hoops for early adopters to jump through, we should be asking what help do early adopters need, where are you stuck and maybe McKinsey or the central [i.e. programme] team can help.* (LA19)

Generally speaking, interviewees from the early adopters reported experiencing a change in relationships and roles from then on:

> *After the panel, the balance slightly changed. There was still a lot of central planning and direction but more autonomy for local areas, and the central [i.e. programme] team's stance became: 'We're here to support you and give you options and advice about how this can be done but ultimately it's a local decision'.* (CG19)

Although this shift was generally welcomed, by spring of 2015, it seemed that the wheel might be turning again. Interviewees and participants in meetings we attended began to be critical of a perceived loss of momentum (partly reflected in the slow progress of early adopter implementation) and a weakening of its strategic leadership capacity due to departures from the programme team. As we discuss in chapter 6, the WSIC programme then appeared to be nearing a critical point that could be of great significance for the extent to which it is capable of delivering integration at scale and pace as set out in its pioneer bid.

Looking forward: from planning to delivery

As we were completing this report in June 2015, the Programme Executive was reviewing the WSIC programme's approach to 'early adopter support' and its governance for the year 2015/16 (WSIC Programme Management Office, 2015b). The relevant paper confirmed that the WSIC programme's focus would be on implementing 'new models of care and establishing the roadmap for scaling and sustaining the approach.' As a result, the programme would continue to provide oversight of delivery of the vision, facilitate shared learning and deliver enabling workstreams at North West London level where consistency is required'. In addition, a 'refresh of programme governance' was required to 'support the shift to an implementation focus'. The timetable is laid out in Figure 16 and shows an explicit alignment between the pan-North West London enabling, infrastructure support projects and the individual early adopter projects. The diagram effectively supports our earlier point about the interdependencies between both arms of WSIC programme development and implementation, and also our observation that it had been less than complete by March 2015.

Two further aspects of the timetable are relevant. The first is the description of the WSIC programme's functions as oversight of delivery, facilitating shared learning and delivering the enabling infrastructure workstreams. This set of responsibilities can be seen as an

attempt to square the circle at the pan-North West London level between an enabling and development support role, and some form of hierarchical function to assure progress. So long as the need is accepted for a multi-CCG/local authority approach within a common vision, some such combination of collective assurance and support functions seems necessary to ensure that service and organisational inter-dependencies are managed and implementation processes aligned. As we have shown, the balance between top-down and bottom-up responsibilities remains an issue in the programme. However, the refresh of governance arrangements to support the transition from planning to delivery offers a timely opportunity to review and agree distribution of roles, responsibilities and resource allocation compatible with securing the programme's intended outcomes through the roll-out of integrated care across North West London. In addition, the value of governance should be enhanced if it is informed by the root cause analysis we have previously suggested of the delays in implementation to date.

Figure 16: WSIC roadmap

Overview of Early Adopter objectives for 2015/16 from last Programme Executive

= Requires central support

Enabler	During 15/16, we expect Early Adopters to achieve the following objectives...[1]	...which means that prior to launch, they must meet the following set of goals
1 Model of Care (MoC) and Outcomes	• MoC has launched in Early Adopter, evaluated and refined it based on early outcomes from first year	• MoC has been developed and agreed across commissioners and providers, and translated into a deliverable and feasible service specification
2 Governance & Contracting	• A formal ACP Board has been established with full ToRs and committees launched • Commissioners have included MoC and capitated budget in Commissioning Intentions (CIs) for 16/17	• Formal principles for working together have been developed and agreed • A Shadow ACP Board has been established and shadow contracting arrangements are in place • Plans are aligned to commissioning intentions
3 Analytics and Informatics	• Data and information has become an integral part of the new way of working enabled via dashboards and information sharing	• Providers and commissioners have signed the ISA • Dashboards are in all relevant facilities and staff are trained on how to use them
4 Finance and capitation	• Commissioners include MoC , capitated budget and risk/reward approach in CIs for 16/17	• Capitation methodology developed and agreed • Systems are in place to capture information
5 Estates	• Refinements to sites have been made based on early outcomes from first year to support MoC	• Sites have been identified and configured to support delivery of new MoC
6 Business Case	• Business case (including plan for scaling has been approved by Shadow (or Formal) ACP Board	• Business case has been developed and approved by the Shadow ACP Board
7 Leadership and team development (Change Academy)	• Initial System Leaders and teams have been identified, and have been enrolled in and completed Change Academy • Additional staff required for scale-up have been identified	• Leadership (clinical and operational) and staff have been identified to support the roll-out • New roles for care delivery have been identified, costed and hired • System leaders and teams have enrolled in the Change Academy

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1 It is unlikely that all Early Adopters will achieve this; instead it is the aspiration for those that will go furthest and fastest in 15/16

2

Source: Paper 3.0 .Meeting of Programme Executive 15 May 2015.

A second, and closely related feature of the roadmap for the current year is a footnote to the statement that 'during 15/16, we expect early adopters to achieve the following objectives…': namely that 'it is unlikely that all early adopters will achieve this; instead it is the aspiration for those that will go furthest and fastest in 15/16'. Because the document was produced after the end of our data collection, we lack information about the background to this apparent contradiction. However, it suggests a difference of view between the programme team and some early adopters about what will be feasible during

2015/16, together with the limits of the programme's ability to apply a universal implementation timetable.

In addition, it raises the question of how to respond to variations in pace, including how and how far to tailor support to each of the early adopters. As a collaborative programme funded by pooled resources from all eight CCGs, the programme team has felt constrained to provide support of various kinds on the basis of something akin to equal shares (PT20). A more radical alternative might be to invest disproportionately in those early adopters that can demonstrate the ambition and potential to implement their vision and model of care most rapidly. To some extent, the gateway for accessing the £750,000 resourcing for early adopter implementation serves that function.

In this chapter, we have sought to present an overview of the approach to change pursued by the WSIC programme to realise its objective of whole systems transformation. Some of the programme's successes and limitations have been identified along the way in this and the two preceding chapters. We bring these together more fully in the final chapter, but conclude here with some more general reflections about the overall approach:

- First, the approach to change has perhaps been characterised **too much by a linear process of structured programme management (for example, through weekly and fortnightly meetings and reports) and too little by softer but equally necessary processes of 'winning hearts and minds' at all levels in the system**, especially the frontline. This aspect of the change process may help to explain why the transition from planning to delivery has been less smooth than apparently anticipated. In making this point, we are not suggesting that the timelines and focus provided by programme management are unnecessary. However, they is no substitute for embedding real understanding, commitment to transforming outcomes for all users and the capabilities to do so. It is the balance between the focus on organisational process and personalised outcomes that is essential here. At the same time, our interviews showed a broadly based perception that the programme began to operate in a less centralised and top-down way as early adopter implementation began. It is the case that the rate of progress slowed thereafter, but our evidence does not allow us to make a causal connection.

- Second, some of the **core difficulties that the WSIC programme anticipated and has experienced in practice require national as well as local action to diminish or eliminate**. Barriers associated with, for example, powers and accountabilities for integrated commissioning, payment systems, information governance, provider integration and accountability, workforce roles and training, all operate within national and mostly statutory frameworks. The national offer to remove such barriers as part of the pioneer programme has yet to be fulfilled, though the national agenda does appear to be coming alongside the North West London one in many of these respects, not least through the Vanguard programme. It is also the case that a large and well-resourced programme such as WSIC may have more space to modify national barriers and boundaries than other integration leaders. Local actors can, of course, be asked to play their hands more skilfully and effectively. Equally, the impact of national barriers on the realisation

of local opportunities has been a continuing constraint on progress in North West London.

- Third, the WSIC programme is essentially an exercise in systems rather than organisational leadership operating at multiple levels in the planning and delivery systems of North West London. **It has to work vertically and horizontally over those systems in an environment dominated by hierarchically organised structures and processes**, while relying formally on the powers other organisations are prepared to cede it, together with its own informal sources of authority and persuasion. One of our respondents likened this role to that of keeping many plates spinning in the air. To a very large extent, the programme still appears to struggling to seek to manage the optimum balance between a number of factors such as: collective leadership and local autonomy; integrated commissioning and integrated provision; NHS leadership and local authority engagement; locally appropriate variation and programme-wide consistency or standardisation. The dimensions and character of these balances are in a constant process of 'negotiated order' and depend on complex judgements, which will vary at different points in time.

The proposed refresh of governance will need to consider such tensions carefully in achieving a balance appropriate to both the current stage of implementation and the demands of its external environment. Ultimately, an assessment of the various points of balance has to be driven by the vision of the programme for better outcomes for local residents. A valuable starting point, therefore, might be to re-visit the programme's vision and outcome statements in the light of this evaluation. If the programme is to have a stronger focus on preventing ill health and promoting wellbeing, it requires a governance framework capable of engaging more fully with local government as a whole and not just adult social care, as well as with the community and voluntary sectors, benefits and other agencies. How far the programme is able to achieve an effective fit between form and function remains unclear, but the resolution of that tension is likely to determine the scope, mechanisms and outcomes of whole systems working in North West London.

Chapter summary

Our research has shown that the WSIC programme team recognised the need for an approach to change that was sensitive to local organisations' autonomy and felt different from what had been perceived as the somewhat top-down style of working in North West London, including the earlier ICPs. This recognition had influenced the adoption of both the co-design and early adopter processes.

Both processes were seen as opportunities to focus functions at the most appropriate level. Hence, co-design at the North West London level enabled work to be carried out once rather than eight times, taking advantage of pooled resources. By contrast, the request for local early adopter proposals to pilot approaches developed through the co-design process enabled adaptation to local circumstances and reinforced local ownership, while minimising the risk of inconsistency by working within a North West London-wide framework.

Despite this rationale, the balance is not settled and uncertainties remain. The approach to change adopted in the WSIC programme is weakened both by the disconnection between its holistic goals and yet NHS-focused principles of change, and by unresolved tensions about how change should be managed. Perhaps most fundamentally, these concern the balance between those functions that are best fulfilled collectively at the North West London level on behalf of the CCGs and boroughs, and those that are more effectively located at the local level.

As the focus of the programme shifts to local implementation, the resourcing of local capacity has assumed increased priority among local actors. The slow pace of implementation among early adopters seems indicative of limitations in the breadth and depth of change supported by the co-design process.

The experience of the WSIC programme to date suggests there is now scope for explicit and structured reflections about the changing nature of form and function across the programme, together with the timing and targeting of appropriate levels of investment and developmental support.

There is a closely related need to clarify the focus and boundaries of the 'whole system' with which the WSIC programme is centrally concerned. From this perspective, the balance between vertical, service-oriented and horizontal, place-based integration becomes more critical. In practice, the WSIC programme has primarily focused to date on the vertical integration of services operating at the boundary between the hospital and the community.

6.   What lessons have been learned?

This is a bold and ambitious programme

This is a large, ambitious and well-resourced programme when compared with the other national integrated care pioneers (Erens and others, 2015). Covering eight CCGs, seven local authorities and a population of two million, the programme mirrors the footprint of the former North West London Strategic Health Authority and North West London Primary Care Trust Cluster. The aims of the WSIC programme are likewise bold and ambitious, seeking to improve the quality of care for families, and empower and support people to lead full and independent lives.

The scope and scale of the WSIC programme are reflected in the extent and sophistication of its management and developmental resources. The CCGs have formed a commissioning collaborative where they: pool transformation resources; manage acute service reconfiguration; coordinate mental health services transformation; and support the development of services out of hospital, including primary care. This CCG collaboration has enabled the creation of a joint organisational structure that provides the WSIC programme with management and financial resources that are significantly greater than those available in any of the other national integrated care pioneers. The WSIC programme has therefore been able to fund and sustain a highly structured and systematic programme management approach. This has been grounded in formal project management processes, and supported by significant management consultancy resource and expertise. In the same vein, the WSIC programme has been able to fund and support extensive stakeholder (including unusually high levels of lay) involvement at all levels of the design and planning of local services. This programme management approach at the pan-North West London level has, unsurprisingly, created some tensions between central and local initiative and developments, which has been a theme running through this research.

It is strongly NHS and commissioner-led

Two further characteristics of the WSIC programme flow from these origins: first, it was commissioner initiated and led; and second, it was predominantly NHS led. Both these characteristics exist to greater or lesser degrees in other pioneers. In the North West London case, they are the expected consequences of the commitment and investment made by local CCGs. The emphasis on inclusivity and co-design has helped mitigate the influence of these characteristics. Nonetheless, the concentration of project leadership within NHS management structures has been associated with a more medical and health service approach to the detailed design and planned implementation of integrated care, compared with the more wellbeing-focused and holistic aims espoused in earlier programme documents.

This finding is not uncommon, and is echoed in the interim report from the evaluation of the national pioneer programme (Erens and others, 2015). It also raises questions about how far the WSIC programme has been built on an evidence base that espouses both vertical integration in the NHS and horizontal integration across individual boroughs and places.

If the WSIC programme is to achieve its original aim of preventing ill health and promoting wellbeing, as well as providing person-centred care, it will require a governance framework capable of engaging more fully with local government as a whole and not just with adult social care. This framework will also need to enable engagement with the community and voluntary sectors, and other agencies such as those in employment, housing and benefits services. At the time our evaluation ended, the programme did not appear to have taken full advantage of the potential contribution of local government beyond that of adult social care's role in facilitating discharge and helping avoid unnecessary admissions or re-admissions.

Many of the responsibilities of local government are related to the social and economic determinants of health, and it is arguably more experienced than the NHS in public engagement, including public involvement in service re-design. In addition, while Health and Wellbeing Boards are at differing stages in their evolution, the local partners in North West London may not have sufficiently considered how far these could develop a stronger contribution to systems leadership.

It is also unclear how far all the early adopters have explored the opportunities for integrating case management systems and their 'back office' infrastructures across the NHS and local government. There may also be a risk that strengthening the central coordinating role of GPs through additional care coordinator and care navigator posts will duplicate functions, leading to poor use of resources or services that are more difficult to coordinate. While these functions may well need to be expanded, it is important to do this within the bigger picture of the care journeys undertaken by, for example, older people throughout their life course. More specifically, this risk arises from the initial focus on models of care for the frailest older people, rather than the population as a whole. The establishment of separate social care and NHS infrastructures for managing personal budgets would similarly risk the duplication of administrative and professional resources.

There has been learning from prior experience

Perhaps the main consequence of being a bold and ambitious programme that aims to 'transform' the health and social care of thousands of people is that expectations of its achievements are inevitably high. Scale and ambition are not new to North West London, nor indeed the NHS (Best and others, 2012). The Inner North West London Integrated Care Pilot that pre-dated the WSIC programme was noted for its scope and scale (Curry and others, 2013), as was the Tri-borough community budgets pilot (Secretary of State for Communities and Local Government, 2014).

With the earlier ICP, objectives included targets for reducing emergency admissions to hospital which were not able to be achieved within the timescale set (unsurprisingly given the national and international research evidence, for example Bardsley and others, 2013).

The WSIC programme took on board some of this learning from the Inner North West London ICP about the time it takes to bring about service change. They opted to have an initial 18-month formative study of the process of design and early implementation, holding back on setting specific objectives and indicators of service change until summer

2015, when the intention was to start a second phase of evaluation focused on tracking actual service change and its influence on outcomes.

This raises two important questions: first, what is the appropriate way of measuring the progress of integrated care schemes at a local (and indeed national) level; and second, at what point should the planning and design of integrated care be considered complete, and the need for study of the cost-effectiveness of actual service change to have come? We return to these issues in our conclusions.

Unintended consequences have proved important

An important observation from this research has been the role of unintended consequences within an integrated care programme of the scale of North West London. While taking a structured approach to programme management can help to drive things forward, it risks focusing attention on the milestones within the project plan and not taking full account of unforeseen changes along the way.

An example of this was the way in which a number of health and care organisations in Central North West London came together as part of the local Better Care Fund plan to bid successfully to run a new Community Independence Service aimed at supporting frail and vulnerable people in their own homes, with Imperial College Healthcare NHS Trust as the lead provider. We were told of how this bid could not have been mounted without the prior collaborative working enabled by the WSIC programme. However, the details of how the Community Independence Service would interact with the early adopters in these central boroughs of North West London were unclear at the end of our evaluation. This highlights a need to think about how to monitor unintended local as well as planned changes (and unforeseen national policy developments) when determining the effectiveness of large-scale change in health and care.

The balance of central and local support needs constant calibration

A theme of this research is the tension between having a large, well-resourced and highly structured programme management approach located at what is perhaps inevitably perceived to be 'head office' (the CCG shared service base), and the need to ensure that early adopter schemes feel well supported and with sufficient autonomy to shape local integrated care plans.

The preparation for, and experience of, the visit by the international review panel in June 2014 appears to have constituted something of a 'tipping point' in the management of this tension. The tightly managed preparation for the early adopter proposals to be considered by the panel provided what came to be considered a checkpoint within the early adopter process, even though the panel's remit was ultimately defined as one of providing advice on implementation to individual schemes. The panel meeting did, in any case, coincide with the point in the process when the focus of the programme was due to shift from pan-North West London co-design stage to local implementation through the early adopters. Nonetheless, respondents identified the shift with the panel event as well, confirming that the balance between central and local influences had begun to take place in the autumn of 2014.

This research suggests that while the people leading the early adopters valued the leadership, energy and resource of the programme team, they were yet to be fully satisfied that the team was providing them with the support needed as they entered into the implementation phase of the programme. The wider programme management approach – with its fortnightly checkpoint meetings at 'head office', location of organisational development, communications and other support within the programme team, coupled with only temporary project management support provided to the early adopters – seemed to demonstrate to many early adopter interviewees the continuation of a fundamentally centralised approach to the management of the WSIC programme, without an evident process of review and reallocation of ongoing resource to local level. Perhaps most fundamentally, questions remained at the end of the evaluation about which functions were best fulfilled collectively at the North West London level on behalf of the CCGs and boroughs, and which were more effectively located at the local level.

The review of WSIC programme governance arrangements initiated by the programme executive group in May 2015 will need to weigh these factors carefully as it seeks to achieve a balance appropriate to the current stage of implementation and the demands of the external environment. If arrangements for integrated commissioning and service delivery, such as local integrated provider models, are to be progressively introduced, clear and robust accountability arrangements will be required to accompany them. Jupp (2015) has helpfully begun to explore such issues in the context of the continuing policy commitment to integrated care, particularly in light of the Five Year Forward View (NHS England and others, 2014).

A focus on involvement only takes you so far

For a programme characterised as large-scale and run in a relatively top-down manner, it is striking that it is so strongly defined by its powerful and deep commitment to the involvement of local people and organisations. Our research has highlighted the time and attention given by the WSIC programme to initiating and sustaining an inclusive process of co-design over many weeks and involving almost 200 lay partners, health and social care professionals, and colleagues from the third sector. The structured approach to the programme management of WSIC was used to drive this process of design and planning, and to challenge the leaders of the programme to ensure that a wide a range of people were able to be involved.

Whilst the majority of people taking part in this research reported the positive benefits of extensive engagement and co-design, some frustration was evident about the time taken up in meetings and the slow pace of actual development of new service models and implementation of local service change.

Certain groups had struggled to be as involved as they would like to have been. For example, local government colleagues had often found it difficult to take part in WSIC planning, partly because of capacity difficulties, and this appears to have contributed to the fact that the wellbeing agenda has been less evident in WSIC activities than its initial statement of objectives might have suggested. In a similar vein, the experience of implementing the early adopters raises questions about the extent to which providers – for

example GP networks, social care organisations, the third sector and NHS trusts – have been adequately involved in detailed planning and implementation.

Involvement in design and planning work is important to the success of large-scale initiatives in health and social care (Best and others, 2014), but is not sufficient. Evidence on the practice of health commissioning highlights the tendency to concentrate time and resource on needs assessment, service design and planning, but much less on contracting, implementation and service review (Sheaff and others, 2015; Smith and others, 2013b). In North West London it has proved challenging for the early adopters to transform the active engagement of providers into a commitment to agreeing new services, changed contracts and different financial flows.

The role of lay partners is powerful yet risky

An aspect of involvement that was consistently cited in this research as being highly valued by local managers, professionals and policy-makers was that provided by the lay partners. Significant time, attention and financial resource was allocated to a sustained programme of recruiting, training, supporting and enabling representatives of local community and health groups to play an active role in the design, planning, and governance of the WSIC programme. This was a departure from the earlier ICPs in North West London, where community and lay involvement was noted in research as being relatively under-developed (Curry and others, 2013).

A commitment to lay involvement on the scale adopted by the WSIC programme can be regarded as potentially a double-edged sword. The extent of engagement is impressive, welcomed, and observed to present important challenge to clinicians and managers (and researchers) as plans are pondered, needs assessed, care models designed and progress monitored. If, however, timescales slip – as has been the case with the WSIC early adopters – there is a real risk that lay partners will become frustrated or even disillusioned, questioning the purpose of their involvement and struggling to account to the groups they seek to represent.

As we concluded our fieldwork in spring 2015, this point had not been conclusively reached, but there were signs of it emerging in meetings we attended and especially in reports on the April 2015 summit meeting. The programme of lay partner involvement seems likely to represent an important and possibly uncomfortable source of challenge about the extent to which the programme has successfully delivered its aims and objectives.

Information and data really do matter

International evidence on the development of integrated care consistently highlights information sharing by means of an individual electronic care record as a vital prerequisite for well-coordinated care (Shaw and others, 2011). The same evidence base also points to the struggle many health and care providers face when trying to link up information systems across departments and organisations, whether due to technical difficulties, professional resistance, or concerns about individuals' data security and privacy (Shaw and others, 2011).

Information sharing has been found to be a recurrent and still unresolved issue within the wider national pioneer programme (Erens and others, 2015). Our North West London evaluation has revealed these issues to again be a barrier to progress, as witnessed by the time taken in working towards data-sharing agreements for the early adopters and in seeking to develop the database necessary to underpin capitated budgets.

Within the WSIC programme, the experience of the Inner North West London ICP – which also faced difficulties with data sharing and IT – was drawn upon when undertaking co-design work focused on data sharing, risk profiling and population segmentation. However, it still proved difficult to move from broad agreements and policies set out in the WSIC Integrated Care Toolkit to actual data-sharing agreements between commissioners and providers. It remains to be seen how quickly and fully such agreements can be operationalised as the early adopters go live and, therefore, how far the pan-North West London design work has enabled progress to be made and sustained.

So is the WSIC programme on track to meet its objectives?

When this evaluation was commissioned, the expectation was that implementation of the early adopters would now be complete and integrated care would be being rolled out across North West London. The programme achieved the initial process of design and planning broadly within its original timescale. It is not, however, on track to achieve its objectives for implementing new forms of local integrated care within the original timescale set, and is running at least one year behind its own schedule. Here we explore some of the issues the programme has encountered.

Co-design of an integration toolkit

The initial co-design phase of the WSIC programme resulted in the production of an integration toolkit – intended as a resource for all the local early adopter and subsequent integrated care schemes in North West London. Although this phase proceeded largely within the planned timetable, its products were somewhat narrower in focus than those implied by the pioneer application, especially in relation to promoting wellbeing through partnership working upstream to address the social determinants of health. Nonetheless, the initial co-design succeeded in producing outputs roughly to time and, perhaps more importantly, in both extending working relationships between different actors and demonstrating the value of involvement by lay partners. As a result, it was influential in creating enthusiasm and momentum for the programme, as the agenda was seen to have shifted from whether integrated care should be promoted, to how and when it could be implemented.

Early adopter schemes

The development of early adopters to pilot the more challenging aspects of the implementation mechanisms contained in the toolkit and adapt them to local circumstances also met the June 2014 milestone of the international panel's visit (although not without some shifts in timescales and outputs as we showed in chapter 3). Over the subsequent months, the timescale slipped for designing and securing agreement to local early adopter care models and their implementation. By spring 2015, the overall

programme was running approximately one year behind the intended plan. The lack of confidence expressed by 60 per cent of early adopter steering committee members in our survey of November 2014 about the WSIC programme meeting its objectives for both April 2015 and April 2016 was a powerful indicator of how the overall pace and progress of the programme had slowed down (though that is not to say the original timetable was a realistic one, as we discuss below).

Moving from design to implementation

All the early adopter schemes have found it hard to move from planning and design to putting in place new integrated care services for local people. However, the initial phase of the Ealing early adopter came on stream in January 2015, and in April 2015 was apparently on track to roll out more widely during the summer. Harrow, Hillingdon, Hounslow and West London also have small-scale pilots currently up and running (see Table 5 on page 71 and Box 6 on page 70 for details). The others remain committed to securing new forms of service provision for local people, and one of the most critical challenges facing the WSIC programme in summer 2015 is how it can sustain energy for, and commitment to, change, and provide necessary support at the local borough and CCG level.

This early energy and pace for the design and planning phase of large-scale change in health care, followed by struggles and delays with implementation and spread of new services, is something that is well-documented in the research literature (Best and others, 2012). The barriers cited within the WSIC programme are likewise in common with those so often identified in evaluations of community-based interventions designed to enable better integrated care: difficulties with data-sharing and IT; securing agreement to new models of clinical care; determining new approaches to payment and budgets; and engaging powerful incumbent care providers to change how they deliver services (Bardsley and others, 2013; Nolte and Pitchforth, 2014).

The timescale for change

An argument made by some people interviewed for this research is that the original timetable for the WSIC programme was over-ambitious. This could however be countered by the fact that North West London has been experimenting with integrated care pilots (Inner and Outer North West London ICPs) for over four years, so should have learned more about the inherent difficulties in moving from bold plans to sustainable local implementation, having also been warned about this through the conclusions of the evaluation of the Inner North West London ICP (Curry and others, 2013). At the same time, senior members of the programme team suggested that short timescales for the WSIC programme were essential; first, because of the 12-month planning cycle and, second, to demonstrate the serious intent behind its commitment to change.

Changes to programme leadership

At the same point at which the WSIC programme is struggling to move from planning to implementation, it is also experiencing significant change in its leadership – the loss of three key leaders from the programme team within six months (December 2014–May

2015). When early adopters need careful nurturing and extensive support as they make difficult decisions about how care will be provided locally, there is a real risk that the wider programme will not have the capacity to tailor support to the new challenges and revert instead to its previous mode of working with a very structured and centralised programme management approach supported by the extensive use of external consultants.

There is, however, a call in some quarters (including from lay partners) for more sustained leadership to be displayed. This underlines the importance of getting the right balance between local and central leadership of service change over the longer term, based on the experience of the last two years. We have argued that colleagues in North West London have experienced difficulty in establishing the necessary balance of leadership and support and need now to reflect in a structured way on what balance between collective and local leadership is required.

Assessing value for money

Nine local early adopter integrated care schemes should have been up and running by April 2014 and yet by the time our data collection finished in April 2015, implementation had begun on a significantly smaller scale than originally envisaged in two schemes, in Ealing and Hillingdon. Wider roll-out of integrated care based on these early adopters was intended for April 2015, and at the time of writing is now scheduled for April 2016. When a significant investment has been made in the direct costs of setting up and running the programme, this raises a very important issue of the appropriateness and effectiveness of the approach taken to change, and one that requires ongoing careful evaluation. The WSIC programme now has to focus on maximising the value of the investment it has made, learning from its experience of change to date, monitoring carefully the progress made by early adopters and the wider North West London health and care system.

Next steps

Here we set out what we consider to be the main issues requiring consideration by the leaders of the WSIC programme, as we conclude our 15-month assessment of the initial phase of planning and early implementation of integrated care.

Using this evaluation to plan next steps

The programme can use the insights from this evaluation to challenge itself in relation to its original objectives and how to address any gaps revealed. At the conclusion of our 15-month initial evaluation, these gaps appear to be:

- Maintaining a wider wellbeing and preventive focus, being careful to avoid an unduly NHS and medical approach to meeting identified needs, and not seeing the early adopters purely in terms of trying to avoid hospital admission in the immediate future.

- Securing continuing and full involvement from local government, the third sector, and private care providers, thus balancing the significant involvement of NHS clinicians and managers, lay partners and commissioners.

- Ensuring that the wider community of GPs in North West London understand and feel committed to the WSIC programme and its early adopters, recognise how their own practice will need to change to enable roll-out of new integrated care services, and feel that support is available to them to make such changes.

- Ensuring that there is a process of accounting to lay partners and their local communities for progress made (or not) and hence securing their longer-term involvement.

Understanding why the programme has experienced delays

As well as assessing where there are gaps in relation to achieving overall objectives, it is vital that the WSIC programme can understand why it is running behind schedule, and what needs to be done to re-gather momentum. When the leadership of WSIC is in flux, and there is pressure for the early adopters to put in place new models of care that result in actual changes to service delivery for older people deemed at particular risk of frailty and hospital care, having such understanding is of particular importance. We suggest that the WSIC programme uses the learning from this evaluation to understand the significant delays that have occurred with implementation, so that lessons are quickly put into practice for the next phase. Not all the sources of delay can be addressed by local actions alone. There is an opportunity for central government to learn from the North West London experience about what still needs to be done to fulfil its offer to remove national barriers to integrated care.

Ensuring that support and project management are in the right place

The balance of resources, support and management of the WSIC programme needs regular calibration, as noted earlier in this chapter. The WSIC programme is at a critical point in its development, for if timescales slip further there is a risk that lay partners, providers and other partners will start to doubt the feasibility of the overall approach. As part of a process of reviewing progress to date, there should be a parallel examination of the support and resources (for example, organisational development, backfill of clinical and lay partner time, and communication and engagement with local service users and health and care professionals) needed by early adopters as they move to finalise and implement new models of care within the current financial year.

Adapting the overall programme management approach

Our research has revealed some misgivings among local health and care professionals and managers about the wider programme management approach used for the WSIC programme. It seems that what worked for the earlier co-design and planning phases may not be as appropriate for the hard work of agreeing service models and making change at a local level. As part of a wider review of programme progress, WSIC programme leaders need to ensure that the programme management approach does not become a strait-jacket, where targets, red/amber/green (RAG) ratings and reports drive activity locally, rather than supporting and enhancing capabilities for local service change.

Continuing to monitor progress and learn in a reflective manner

The WSIC programme has shown willingness to be monitored in a detailed and open manner, in particular through this evaluation, which has entailed regular feedback and challenge. It should continue to put in place systematic methods for evaluating and measuring success, including in relation to improvements in care, user and staff satisfaction, and value for money. As the programme has moved from co-design, planning and early attempts at implementation – evaluated using largely qualitative methods intended to inform the process of learning and change – so the assessment of progress will need to adopt a more quantitative focus on actual service improvement, including metrics that enable conclusions to be drawn about overall value for money.

Lessons for others

Both the pioneers in general and the North West London pioneer more specifically have committed to sharing the lessons emerging from their experiences within the pioneer community and with other localities seeking to develop integrated care 'at scale and pace'. We have sought to draw out from our data lessons that may be of interest to that wider audience. Inevitably, they are broadly similar to those above and we have summarised them in Box 7.

Conclusion

The WSIC programme in North West London is large in scale, ambitious and well resourced when compared with other national integrated care programmes (Erens and others, 2015). The scope and scale of the programme are reflected in the extent and sophistication of its management and developmental resources. It has also been remarkable in its commitment to involving many local people and organisations, and seeking regular critique of its approach, progress and prospects. The commissioning of this study as an early formative evaluation providing feedback and challenge is itself evidence of such openness and readiness to learn.

The initial co-design phase attracted enthusiasm and succeeded in producing outputs roughly to time and, perhaps more importantly, in both extending working relationships between different actors and demonstrating the value of involvement of lay partners. Implementing the early adopter schemes proved much more difficult, and timescales slipped considerably. As the WSIC programme seeks to move from design to delivery at scale, it will be vital for the programme executive and its constituent members to identify the reasons for this delay and address those that are within local control.

An important juncture has been reached, as changes occur to the leadership of the programme, the NHS England Five Year Forward View (NHS England and others, 2014) becomes a central feature of NHS planning, and the WSIC programme is held accountable for its use of resources and progress to date. Within the wider context of constrained public finances and the forthcoming Comprehensive Spending Review in November 2015, the requirement to demonstrate the value derived from the significant investment made in the WSIC programme reinforces the need to put more specific targets in place around service utilisation, patient and user experience, and overall cost-effectiveness.

The WSIC experience reveals valuable lessons for other policy-makers and practitioners leading integrated care schemes, namely in the challenges it has had in moving from planning and design to implementation of integrated care, and how it has sought to address these. As the programme moves forward, it is important that its leaders – the eight CCGs, seven boroughs and their organisational partners – sustain and build on the early adopter pilots and translate their experience into delivering sustainable service change across North West London. They will need to avoid what so often happens in the NHS: that not enough time is provided to bring about the changes needed to local services before the policy and management focus moves onto a new initiative.

The story of integrated care initiatives is one of great expectations often not met. Ambitions typically run ahead of the changes that occur on the ground. The early energy and pace that goes into the design and planning phases of large-scale change, as we have seen from this study of North West London, is often followed by struggles and delays with implementation. Policy-makers must set realistic expectations, provide sustained and tailored support, and allow time for clinicians and managers to deliver changes to the ways in which patients are cared for. Alongside this, there is a need for careful and robust monitoring of progress over the longer term, feeding into local governance and accountability arrangements, so that investment and implementation deliver the transformational changes promised at the outset.

> ## Box 7: What can others learn from the WSIC experience of designing and implementing integrated care?
>
> **With a large integrated care programme, there are both economies and diseconomies of scale**
> A large-scale integrated care programme such as WSIC offers benefits in terms of enabling a whole health economy approach and pooling CCG resources for management and developmental support. The scale does, however, create additional complexity in terms of accountabilities, governance and management processes, with inevitable tensions arising from having a central strategy and support team alongside local initiatives.
>
> **NHS management has a tendency to dominate within integrated health and social care**
> Given the national and relatively centralised nature of NHS policy and management, and the constraints and lack of capacity in local government, it is not surprising that integrated care programmes have a tendency to feel somewhat dominated by NHS and health service concerns. In North West London, this has meant that more wellbeing-focused aims have at times felt secondary to putting in place services for people with complex health and care needs.
>
> **It is better to promise short and deliver long**
> Perhaps the most striking lesson from the WSIC programme is the wisdom of avoiding the temptation to promise early changes to emergency hospital activity and costs as a result of developing a programme of integrated care – something which has almost always resulted in frustration and disappointment (Bardsley and others, 2013). With the WSIC programme, the programme team elected to have an initial period of planning and design, during which the evaluation focused on assessing the process of stakeholder engagement, and early progress in establishing new services.
>
> **The balance of central and local support and resource needs constant adjustment**
> In any health and care development programme, constant attention will need to be given to the balance of support and resource at 'head office' or in a central programme team, and that which is allocated to

localities or pilots. Formative evaluation support can be helpful here, as can the development of regular, open and honest reflective workshops involving all parties.

A focus on involvement and relationships will take you only so far
There is a strong tendency for integrated care initiatives to invest heavily in co-design, planning and engagement work that is intended to foster stronger relationships across organisations, professions and the boundaries that so often lead to fragmented care. The experience in the WSIC programme, in common with wider research evidence, is that it is challenging to move from co-design and engagement to service change and implementation. Alongside involvement, there needs to be parallel investment of time and resource in transactional issues such as contracts, data and IT, and the development of new work processes, focusing on the main parties to be affected and putting in place arrangements to arbitrate between them as tough issues emerge relating to workforce, funding and service change.

Lay involvement can be a powerful but uncomfortable tool
There has been extensive lay partner involvement in designing, planning and governing the WSIC programme. This was impressive, and came to be welcomed by a wide range of stakeholders. In particular, it was reported to have provided an additional and different source of challenge to clinicians, managers and others. There are, however, unanswered questions about how far the lay partners involved in the programme can most effectively become anchored in wider community networks within each of the local areas, and how the relationship between these partners and local managers might be tested if the implementation of integrated care continues to fall behind schedule.

Information and data really do matter
In common with other UK and international programmes of integrated care, the WSIC programme team has found that issues of data sharing, governance and IT have caused delays to the overall programme of service change. A commonly agreed need to share data for the purposes of improved care coordination so often runs into difficulty when the practicalities of interoperable systems, data-sharing agreements, and professional or organisational culture come into play. These and other barriers, including payment systems, governance structures and organisational fragmentation, cannot be fully removed without national action, such as that promised (but not yet delivered) when the national pioneer programme was announced.

Local government has more than adult social care to offer
Social care has an essential role in supporting the day-to-day delivery of health services. It is also part of wider local government structures, and councils possess expertise, infrastructures and leadership responsibilities that could greatly assist the transformation of local whole systems. Both the NHS and local authorities should consider whether that potential is sufficiently recognised and exploited in the context of integrated care.

Formative feedback
Commissioning a formative evaluation is part of a reflective and learning style in policy development and implementation. It is particularly appropriate in situations of complexity, characterised by multiple stakeholders and difficulties in establishing the causal relationships between activities and outcomes. It requires evaluators to be confident in their relationships with their commissioners, and the latter to be prepared to receive messages that are potentially uncomfortable or inconvenient. It also requires time and structure: formative feedback is not a corridor conversation. In addition, since evaluators cannot evaluate their own impact, it requires open dialogue between evaluators and commissioners to learn about this impact and the consequences of the formative approach.

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Appendix: Detailed methodology

Overview of the evaluation

The Nuffield Trust and the London School of Economics and Political Science (LSE) were commissioned by Imperial College Health Partners and the North West London Collaboration of CCGs to evaluate the development and implementation of the initial design and piloting phases of the North West London Whole Systems Integrated Care (WSIC) programme over the period from the beginning of February 2014 until the end of April 2015.

The evaluation was primarily qualitative in nature, and sought to provide an independent assessment of:

- the way in which the WSIC programme was designed
- its involvement of local stakeholders in its processes of design
- the development and early implementation of early adopter schemes (local pilots of integrated care)
- the extent to which the WSIC programme appeared to be on track towards its objectives.

Like the WSIC programme itself, the evaluation had two phases:

1. Assessing how the various local stakeholders were engaged in co-designing the programme, and giving our early impressions of how priorities and plans for the early adopters had been developed (February to the end of June 2014).

2. Studying the development and progress made by the early adopters, including a sample of four selected as case studies, and assessing how far the WSIC programme overall appeared to be on track towards its objectives (July 2014 to the end of April 2015).

Methods used in the evaluation

Overview of methods

Our methods for undertaking the evaluation included:

- documentary analysis
- observations of meetings and site visits
- semi-structured interviews
- feedback workshops
- a focus group of early adopter project managers and clinical colleagues
- a survey of early adopter steering committee members (November 2014)
- a survey of GP practices in North West London (March to late April 2015).

These activities took place between early February 2014 and late April 2015. In total, we conducted 73 hour-long interviews, face to face or by telephone. Interviewees included managers and professional staff from: the acute sector; clinical commissioning groups (CCGs); community and mental health services; local authorities; lay partners; third sector representatives; and frontline staff. We also observed approximately 120 hours of meetings at the pan-North West London and local early adopter levels. More details of these activities are given below, broken down according to the phase of the evaluation in which they were undertaken.

While our formal data collection period finished at the end of April 2015, we have in some cases included material gathered after this date when it seemed pertinent to do so. Where this has occurred, it has been clearly marked in the report.

All interviews were recorded and transcribed, and subsequently analysed using a framework approach and the qualitative software NVivo. Observation notes were written up by hand and incorporated into our analysis of interviews. Interviewees and other participants have been anonymised for this report.

Ethical approval for this work was received from the Research Ethics Committee of the London School of Hygiene and Tropical Medicine (LSHTM ethics ref: 7215).

Formative element of the evaluation

The Programme Executive group wished to commission a formative evaluation to enable timely learning and feedback to contribute to the programme's continuous improvement and eventual success. The formative approach was, therefore, an important aspect of our evaluation. Its design provided for regular interaction between the research team and local stakeholders through three main mechanisms: co-design of research methods; early feedback by researchers of emerging findings; and reflective sessions where the researchers offered WSIC programme leaders suggestions about next steps, based on research data and analysis. It should also be noted that the evaluation also had a summative element, as the research commission's key questions and issues made clear.

The principal routes by which formative feedback was provided broadly comprise the following:

- May 2014: Presentation of emerging findings from our interim analysis at a workshop with stakeholders from across North West London.

- May 2014: A feedback meeting with the programme team to provide reflections, drawn from our interim analysis, on areas that the early adopter review panel on 11–12 June 2014 might wish to explore with the early adopter teams.

- July and August 2014: Presentation of interim findings to early adopters and other stakeholders at two separate workshops. These workshops also helped to co-produce our case study selection and design for phase two of the evaluation.

- September 2014: Feedback meeting with members of programme team to review experience of formative processes to date, the implications of phase two data collections and future interactions between the two teams.

- November 2014: At a North West London briefing seminar for a WSIC study tour to the US, a presentation of revised interim findings and principal challenges for early adopters identified at the August workshop. Discussion around which elements were particularly relevant for the study tour to explore whilst visiting the US sites.

- December 2014: Meeting with lead managers at an early adopter site to help shape arrangements for our online surveys.

- December 2014: Stocktake with Senior Responsible Officer of the programme team of initial early findings from senior stakeholder interviews and work with early adopters, and agreement to arrange a roundtable discussion of such issues with selected stakeholders in early 2015.

- January 2015: Formative feedback roundtable with members of the programme team and lay partners to discuss some of the challenges identified in our interim report and how these had developed over time. Presentation of the findings from our completed survey of early adopter steering committee members undertaken in November 2014. Jointly framed questions which were thought to be important as the WSIC programme team looked ahead to the next phase, including the question of how the early adopters could best be supported.

- February 2015: A Q&A session with a visiting external advisor from the US during which we discussed some of the emerging findings presented initially during the formative feedback roundtable in January 2015.

- March 2015: A note submitted to Imperial College Health Partners (ICHP) at this commissioner's request to highlight the evaluation team's current understandings of WSIC implementation, reflecting and building upon feedback provided to the programme team in January 2015. The note was considered at a meeting of the ICHP Board on 12 March 2015.

- March 2015: At one of the fortnightly meetings of the early adopter project managers, feedback of results from our survey of early adopter steering committees by a member of the evaluation team.

- April 2015: A focus group undertaken as the concluding part of our evaluation of the early adopters to give those involved with the early adopter projects locally an opportunity to share amongst themselves their experiences of implementing their project in a discussion facilitated by members of the evaluation team, and to enable us to compare their experiences as we finalised the conclusions of our evaluation.

Breakdown of research activities according to phase of the evaluation

Phase one of the evaluation (February to June 2014)

During the initial phase of the study, the evaluation team focused on describing, understanding and assessing the context within, and the processes through, which the various North West London integration partners planned the detail of the overall WSIC programme. In addition to the formative feedback listed above, this entailed:

- A total of 30 hour-long interviews with a range of stakeholders, including NHS commissioners (n = 6); NHS providers from the acute, mental health, community health or primary care sectors (n = 6); local authority officers (n = 8); members of the programme team (n = 5); lay partners (n = 3); and others (n = 2).

- Observation of approximately 60 hours of meetings or workshops.

- Analysis of broad range of programme documentation, including the WSIC Integrated Care Toolkit.

- Review of UK and international literature and developments regarding integrated care and commissioning, including close liaison with the national evaluation of Integrated Care Pioneers.

Phase two of the evaluation (July 2014 to April 2015)

During the second phase of the study, the focus shifted to a certain extent from the pan-North West London level to the nine early adopters to give greater emphasis to dynamics and developments at the local borough level. We tracked the progress of all of the early adopters but also took a case study approach with the early adopters in Brent, Central London/Westminster, Ealing and Hillingdon. Our research during this phase included:

- A total of 16 hour-long interviews with a range of stakeholders at the pan-North West London level, including NHS commissioners (n = 3); NHS providers from the acute, mental health, community health or primary care sectors (n = 3); local authority officers (n = 4); members of the programme team (n = 3); lay partners (n = 3); and other (n = 1). The sum of interviews broken down by sector does not equal the total number of interviews, as one individual was interviewed at two different points during this phase.

- A total of 27 interviews with individuals working in our case study early adopters, including NHS commissioners (n = 10); NHS providers from the acute, mental health, community health or primary care sectors (n = 8); local authority officers (n = 6); third sector providers (n = 2); and other (n = 1).

- 60 hours of meeting observations, both locally at our early adopter case study sites and at the pan-North West London level.

- Continued analysis of extensive programme documentation, including early adopter outline business plans and the WSIC Integrated Care Toolbox.

- Two online surveys: one of steering committee members within each early adopter, and one of GP practices in every North West London CCG. These are described in greater detail below.

Our online surveys

To complement our in-depth case study approach with four of the early adopters, we conducted two surveys with a wider group of participants to capture wider perceptions of the programme. The first of these was of steering committee members within each of the nine early adopters, and the second was of GP practices across North West London.

The survey of early adopter steering committee members was sent out on 13 November and closed on 17 December 2014. Designed using the online software Survey Monkey, it asked about members' perceptions of their early adopter's progress, the usefulness of the WSIC Integrated Care Toolkit and its design process, as well as different groups' involvement in the project. A total of 109 steering committee members responded to the survey; an overall response rate of 60 per cent. However, the response rate varied considerably among the individual early adopters, ranging from 31 per cent to 80 per cent.

The second survey was aimed at GPs in North West London and was distributed by the various CCGs. One GP in each practice was asked to complete it. The majority of CCGs distributed the survey on 24 March 2015, with two CCGs sending it out the following month. The survey closed on 8 May 2015. It was also designed using the online software Survey Monkey. A total of 160 responses were received; a response rate of 39 per cent (assuming that one person per practice completed the form). Of those who responded to the survey, 11 per cent identified themselves as practice managers, administrators or practice nurses (19 individuals). These responses were included in our analysis.

Although the survey of GP practices asked about awareness of the WSIC programme, it was designed primarily to gather views on integrated care and what needs to happen locally to achieve change. It also collected baseline data on perceptions of GPs' relationships with other sectors. The results of this survey were used to inform this report, and individual feedback reports distributed to local areas.

Slideshows detailing the results of both surveys are available.

Selection of the case studies

Our evaluation combined analysis of pan-North West London activities with an in-depth exploration of four of the nine early adopters working at a local level. In order to decide which four to work with, we undertook a co-design exercise with representatives from all the early adopters, the programme team and other stakeholders, using workshops to draw out criteria for the selection of case study sites and to identify issues that we might investigate. The following list summarises the criteria and issues to emerge from that process and which were then taken into account in the selection and design of the four case studies.

Where is the early adopter based?

- **Geography:** At least one early adopter should be from an outer borough, and at least one from an inner borough of North West London.

- **Complexity of health economy:** We wanted to ensure we had at least one early adopter with a relatively discrete health economy (i.e., focused on a small number of providers), and at least one with more complicated patient flows.

- **Contextual differences:** We wanted to capture the effects of current acute hospital reconfiguration, given its likely impact in driving out-of-hospital care changes.

Who is involved in the early adopter?

- **Target population characteristics:** Taken together, the case study sites should cover a range of the target population groups.

- **Partners delivering the intervention:** Taken together, there needed to be no significant gaps in provider type, including third sector providers, among the case study sites.

- **Readiness for implementation:** We wanted to ensure that the case study sites represented a range of starting points and readiness for implementation. Here, we considered factors such as the progress of the different early adopters in achieving certain early milestones and the state of development of GP networks, one of the lynchpins of the whole systems approach.

How will the early adopter be delivered?

- **Scale of initiative in terms of quantity:** We wanted to have a good spread in terms of the number of population groups covered by each initiative (e.g., one vs. several) and the size of these populations.

- **Scale of initiative in terms of quality:** We recognised that focusing on a knotty issue in a small population might be just as 'ambitious' as focusing on a large population.

- **Extent of social care involvement:** How 'medical' is the model? What is the apparent extent of social care involvement in the model of care being proposed?

Quotes

Quotes from our interviews are cited using three-letter alphanumeric codes, which represent the sectors of the various interviewees plus a row number in our master list. The sectors are named as follows: CG for NHS commissioner, FA for facilitator, HP for health provider, LA for local authority, LP for lay partner, PT for programme team and TS for third sector. The names of interviewees from each sector in our master list were not ordered alphabetically, but rather determined by random numbers generated for this purpose. The digit within the alphanumeric code therefore has no further meaning beyond its use as a reference.

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